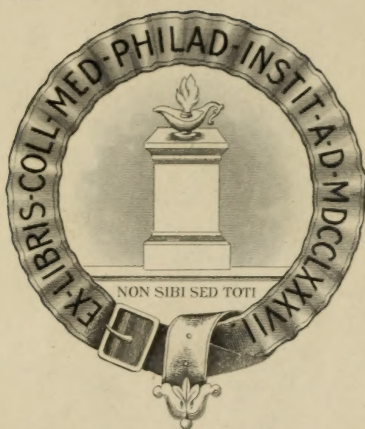




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# The HAHNEMANNIAN Monthly.

VOLUME FORTY-SEVENTH

JANUARY TO DECEMBER,  
1912

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EDITED BY

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State Society Editor, D. P. MADDUX, M. D.

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PHILADELPHIA,  
1912





# THE HAHNEMANNIAN MONTHLY.

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JANUARY, 1912

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## SOME IMPERATIVE PROBLEMS OF MEDICINE.

BY JAMES KRAUSS, M. D., BOSTON, MASS.

Permanent Secretary of the American Association of Clinical Research.

(Read at the Public Meeting of the American Association of Clinical Research, on  
September 27, 1911, at Boston.)

IN a public lecture of an educational tendency, such as our Association requires us to give once a year, it may not be too paradoxical to say that of all imperative problems of medicine the first problem is to ascertain what medicine really is.

Last year we showed how medicine, for some time the instrument of superstition, of supernaturalism, of metaphysics, has through observation, experiment and generalization, become a science. We showed how occurrences, ordinary facts, become the foundation for scientific facts; how general facts, generalizations from related facts, become scientific facts as they describe, explain, connect correctly actual occurrences.

Facts, occurrences, are barren, incomplete, of no consequence really without the truth that is behind them, the truth that develops the relationship of facts, the principles which permit us to use the knowledge of this relationship with precision in the every-day business of medical work. We must have facts, for they are the materials with which we are dealing, but we must have much more than facts, we must have the moving ideas, the principles, the truths that are behind the medical facts, and it is these ideas, these truths behind our medical facts, that really constitute the imperative problems of medicine of the present day.

History gives us the perspective. For centuries, when active treatment of patients was instituted—and when was it not?—the treatment followed was on this line: Here is the body of a patient, a structure admitting of a more or less mechanical or chemical consideration. To affect such a massive structure in disease, substances in quantities sufficiently massive to make a mechanical or chemical impression must be used. Then came the year 1799. In that year, for the first time in the history of medicine, we meet with the small dose. The small dose was introduced by Hahnemann.

It appears that one problem of medicine is very nearly settled: the necessity of the small dose. The small dose has come to stay. The argument has been made repeatedly that if patients can get well with small doses of drugs, patients may get well without drugs. A whole school of therapeutic nihilism has risen, disappeared, and risen again upon this argument. It is not necessary to mention religious healers who have attempted to cure people on the assumption that they require nothing, as disease is immaterial, health is immaterial, only tribute is material. Even medical men have tried to set aside symptoms by suggestion and analysis, but those of us who are in active practice have found repeatedly that when the patients are not overwhelmed by authority or a momentary subjective inclination to fall in with the suggestion and direction of the physician, symptoms that are true symptoms, naturally remain. Actual disease requires actual treatment. There can be no question as to that. What it does not require is over-treatment, massive dosing.

The small dose has become justified through pathology, through physics, through chemistry, through biology. To-day we know definitely that the body is made up of millions and millions of cells of the smallest dimensions, microscopic and ultra-microscopic bodies. In diseases, it is these minute cells, and not Alpine structures, that are affected. We also know that nature works only with the smallest mathematical magnitudes. It has been calculated on the principles laid down by D'Alembert, Maupertin's, Euler and other mathematical physicists, that one milligram (0.001) of mass, that is, about one fifteen thousandth ( $1-15000$ ) part of a grain in weight, represents about sixteen million million millions ( $16,000,000,000,000,000,000$ ) of molecules. The diameter of a single molecule is four tenmillionth ( $4-10,000,000$ ) parts of a millimeter or one ninety-eight thousand four hundred twenty-five millionth



(1-98,425,000,000) part of an inch. These dimensions relate only to molecules, physical units, not to atoms, which are chemical units and which upon combination go to form physical units. Drugs penetrate the body not in mass, but through molecular, atomic, ionic dissociation. Van H. Hoff, the great creator of chemistry in space, has proved that salts in dilution obey the laws not of solids but of gases, that salts in solution do not have their molecules intact, but are broken up into ions bearing electric charges. One gram (1.0) of salt, or about fifteen (15) grains, dissolved in fifteen hundred (1,500) tons or over fifty millions (50,000,000) ounces of water, can be made to carry an electric charge. It has been calculated (Francis, *The Electron Theory*) that the repellent force of the electrons within the atom is a trillion trillion times greater than gravitational attraction. The physical and chemical properties of solution of salts depend to a large degree on the activities of electrons, electrically charged ions. The energy inherent in ions is almost beyond belief. If we take three one thousandth part of a gram (0.003) of polonium, the element discovered by Madame Curie, and spread it out along a strip of copper one centimeter (1cm.) wide and as long as the equator, that is, about twenty-five thousand (25,000) miles, three centimeters (3cm.) or a little over an inch of this elongated and attenuated strip of polonium would suffice to discharge the electroscope, an instrument indicating electric influences. Pasteur and Wright proved that minute rather than massive doses of vaccine must be employed for the best results. The division of drugs into their molecular, atomic or ionic constituents facilitates their reception by the cells of the diseased organism.

This brings us to another problem of medicine. Is there really such a thing as cure, or is it merely a sort of immunity that medicine may produce? Pasteur laid the foundation for what has come to be known through the further labors of Koch and Wright and many others as bacterial therapeutics. Bacteria and their products have been utilized in the treatment of infectious diseases upon the basis of what some have been pleased to call the law of immunity. What is immunity? Immunity is the physical ability to resist disease. What is the law of immunity? It is the assumption that patients get well without any treatment from outside, that the organism assailed by infection creates within itself new products for the warding off, the neutralization and the destruction of assailing infec-

tious material, and that thereupon the organism retains a certain degree of resistance to such further infection.

Pasteur thought that during the multiplication of offending microbes in the body they exhausted some substance necessary for their maintenance and then ceased to grow and the individual recovered with consequent immunity. Metchnikoff (1883) disclosed the power of the white blood corpuscle, primarily the small polynuclear variety and secondarily the large mononuclear variety, to grasp, swallow, digest and gradually absorb offending bacteria (phagocytosis). Some bacteria cause disease by multiplication and progressive invasion. Other bacteria cause disease by elaborating specific soluble poisons, toxins. These toxins when thrown into the circulation give rise to specific bodies the antitoxins of Behring (1892), which are specifically antagonistic to toxins and which neutralize the toxins according to Ehrlich, through chemical union, just as an acid neutralizes an alkali. When bacteria reach the circulation, they are acted upon by constituents of the normal blood, the normal aletin of Buchner (1889), or bacteriolysin of Pfeiffer (1894) or complement of Ehrlich (1899), and by specific substances which form in the blood only in response to specific bacteria, the bacteriolysins of Pfeiffer which dissolve the agglutinins of Gruber and Durham (1896) which coagulate or clump, the precipitins of Kraus (1897) which precipitate the bacteria, and the opsonins of Wright and Douglas (1904) which prepare the bacteria for readier digestion by the white blood corpuscles. In the disposal or breaking up of the bacteria, their intracellular toxin or endotoxin may come into action, and as this toxin does not give rise to the formation of antitoxins, there may be an aftermath of intoxication which may be taken care of by the normal alexin of the blood.

It is the old, old story that nature, the *vis medicatrix naturæ* of the Latinized minds of the profession, the biological make-up of the human organism, is self-sufficient. It is the old, old error which sooner or later, consciously or unconsciously, every physician recognizes. Behring found that natural antitoxin was not always sufficient to neutralize the toxins of bacteria. He therefore produced animal antitoxin to be injected into human individuals when they are short of antitoxin. This is the principle of serum therapeutics. Pasteur, Koch, Wright, found that the white blood corpuscles of the diseased organism were naturally not always sufficient to dispose of the offending



bacteria, so Pasteur took the living virus, the secretion, and old cultures of bacteria, Koch took the toxins of pure bacterial cultures, attenuated them and injected them into human individuals, as Wright puts it, to stimulate them to a greater production of defensive agents. This is the principle of vaccine therapeutics. Ehrlich found that drugs introduced into the circulation create their antibodies as bacterial toxins create their antitoxins, that repeated dosage produces immunity, by direct, specific action on the parasites (parasite tropic) or on the body cells (organotropic). There is a specific chemical affinity between specific living cells and specific chemical substances. A parasite-destroying drug will kill either all the parasites with one stroke or will kill only a certain number of parasites and the remaining ones will be destroyed by the rapidly forming antibodies in the blood. This is the principle of Ehrlich's chemical therapeutics.

Of course, we have to assume if we wish to conclude. But because we conclude it is not proved that what we assume is true. What we assume is either demonstrable or not demonstrable, if demonstrable we must demonstrate that it is true. If not demonstrable, the results must speak for our assumptions. If the results are all that they should be, the assumption is correct. If the results are not all that they should be, the assumption may still be correct as far as it goes, but is not comprehensive enough, is wanting in its terms and implications, or the assumption is faulty throughout. The difference between a mere assumption and a real theory is this: A theory is, if not proved, at least provable. A theory is comprehensive in its terms and implications. A theory is true in its results.

What are the results? It appears that many patients fail to generate sufficient antibodies, fail to produce a sufficiency of defensive agents, for all patients treated with antitoxin or vaccine do not get well. The far-reaching claims of therapeutic benefit for serum and vaccine immunization are not borne out by clinical observations. Instead of immunity, there often occurs hypersusceptibility. Instead of a cure there are relapses. There is at best an armed peace between infection and defense, ready to be broken at the first opportunity. When patients recover, they are not as they used to be before they were attacked.

The reason is not far to seek. It is impossible to introduce any substance into the body, be it food, drug, serum or vaccine,

without alteration in the process of incorporation. Whether we assimilate or eliminate the substance incorporated, there is alteration of body and substance. Food that goes to make up the wear and tear of flesh and bone, protein, is stored up in early life, but in adult life, the excess is eliminated, partially oxidized, by way of the kidneys. Fatty and starchy food that goes to make heat may be stored in excess as fat at all times and need not be promptly eliminated through the lungs, the skin and the kidneys. Just as nutritious substances become incorporated, just as they enter into combination with cell protoplasm, so do offending substances. It can be nothing but pure assumption to say that certain substances will attack therapeutically only bacterial cells and other substances will attack only cells of the body proper. It is pure assumption to say that the reactive products of infection confine themselves to their specific cause. Roux showed that tetanus serum is antitoxic not only to tetanus toxin but also to snake venom. Snake venom is active also against scorpion poison. Yeast cells increase phagocytosis for yeast cells and opsonic activity toward staphylococci (McFarland, L'Engle, etc). Animals immunized with egg albumen of the chick yield precipitins for the egg albumen of related birds (Coplin). It is a mere assumption to say that the power of immunity will stop with resistance to bacteria and their products and will replace only those tissues and fluids that are cast off in the process of immunity. The regenerative process tends to overproduction. According to Weigert, among the latest observers, and according to the best observers of all times, the tendency of the natural process of repair is to exceed the absolute requirements. The *vis medicatrix naturæ* works blindly.

The vital problem of medicine is the cure of patients. There are not only infectious diseases, which have been treated on the basis of the so-called law of immunity, but there are other diseases—developmental, nutritional, traumatic,—which require treatment, some adjustive treatment, some curative treatment. In adjustive treatment we aim at a mechanical effect. We adjust the human mechanism in certain of its parts, physical, chemical, psychical, according to physiological tenets and requirements, and let the disordered organism put itself in order. In curative treatment, we aim at a substitutive effect, a dynamic effect. We introduce into the body a new, extraneous energy; we substitute the more or less transient energy of the remedy



for the more or less permanent activity of the disease energy; we cure what the native power of the organism alone cannot cure.

It is necessary, therefore, that we know with exactness the power of action that rests in our tools, in our remedies. Just as we palpate, inspect, auscult, percuss the body to detect and weigh symptoms of disease, disease effects, just so we ought to palpate, inspect, auscult, percuss the body to detect and to weigh, by the symptoms that drugs produce, drug effects. We cannot tell what there is in a drug from its physical qualities (Galen), from its resemblance to certain parts of the body (Paracelsus), from its sensory attributes, or even its chemical constitution. The only way we can learn what there is in a drug is by studying its effect on the organism. For centuries drugs were given to the sick and effects on the sick were taken to be drug effects, and on that basis drugs were continued to be used on the sick. This *post hoc ergo propter hoc* medication is the principle of empirical medicine. On the other hand, Haller (1771) suggested that if we wish to know the action of drugs, these drugs should first be tested on the healthy human body. The first complete test of a drug in the healthy human body was made by Hahnemann on himself during the years 1789 and 1790. There were those that followed him, and those, like the school of Schmiedelberg, that preferred to learn the drug effects from tests on animals rather than on healthy human beings. From the ascertained action of drugs on the healthy organism, animal or human, or both, it is determined how drugs will act upon sick persons, and on that determination the drugs are used on sick persons. This is the principle of rational medicine.

The testing of drugs on the healthy human organism was the means of bringing forth what I conceive to be the most far-reaching discovery in medicine: a drug produces in the healthy human body not merely one symptom but series of symptoms, subjective and objective, corresponding to entire disease pictures. We can diagnose drug remedies as we can diagnose diseases by their manifestations in the human body. The physician who allows himself to forego the knowledge of this fact lives in assumptions and practices on hypothetical indications.

In a science like medicine, which deals with the complexities of structure and function comprised in human life, constant assumptions lead only to uncertainties. Yet nowhere is cer-

tainty so much to be desired as in medicine. Medicine is deluged with unorganized material. Because we have thousands of years of medical practice behind us, it does not mean that our records represent the value of as many years of scientific progress. Because men devote time and effort and money on research work in medicine it does not follow that that work is good, and in the direction of medical certainty. The world is flooded with bad research work. Millions and millions of money are spent for research work that is not research work. Medically, most of the work goes beside the point. The money, often the offered balm for unforgotten sins, might just as well remain in the hands of the sinners. Numbers do not necessarily give exactness. Experiments are, at best, factitious. "Facts are stupid things," said Agassiz, "unless brought into connection by some general law." This, as we have shown, cannot be done by assumptions that defy proof. But what assumptions cannot do, a correct method of procedure that requires no assumptions can do.

The American Association of Clinical Research is in possession of such a method. The method is known as the conjoined clinical method of research. It forestalls errors of observation and experiment to be corrected by later observations and experiments. The method corrects observational and experimental error by simultaneous observation and experimentation. It admits of no preconceived notion. What it requires is only unquestionable facts. It does not require details to be garnered by centuries. The facts of the immediate present are enough. It takes primarily nature's experiments as a whole, through the process of observation, and secondarily man's experiments as factitious combinations of circumstances made to reproduce nature's facts, through the process of experimental observation, but does not accept a part for the whole nor factitiousness for naturalness. Statistical tabulation presupposes uniformity of clinical conditions, but such uniformity does not exist. Tabular statements cannot give the essentials, the minutiae, the differences which are necessary for adequate, precise, comprehensive, complete conclusions. Experiments cannot always reproduce all the circumstances under which observations are made, cannot reproduce the clinical continuity, and even when applied to a stationary phase, are not necessarily correct, exact or valid. But it is different when we proceed upon the method of conjoined observation and experiment. We can



consider the human element throughout its continuity, in all its minutiae and differences. We can verify one observation by another observation, the corrective or control observation taking place at the time of the original observation.

There is no physical hindrance to this method. We have now microscopes where two observers can observe the same object at the same time. Astute men already advocate this method for teaching purposes. If good for teaching and study, the method is good for investigation, for research. The method is so simple that, perhaps, the greatest objection to it, if such an objection could sanely be made, would be its simplicity.

The method is as follows: Two men make and record their observations simultaneously and independently on the same patients. One man applies the treatment in one case; the other man applies the treatment in the other case; but both men observe and record throughout, independently though simultaneously, what is done and what the results may be in every case.

Thus we obtain unquestionable facts. The Association has issued research leaflets which give in concise form directions for the natural observation of clinical phenomena in the all-inclusive sense of disease phenomena. The observation may be carried on in the smallest as well as the largest hospitals, and even in private practice where two men work together. As soon as the Association will have its own hospital—and it will not be many years before it will have its own—there will be a home for conjoined clinical research work for the conjoined observation and collection of clinical experiences, and it will make the beginning of the end for much of the worthless, foolish research work now going on, worthless and foolish because it lacks correct methods of attack.

The problems of medicine require observers for the collection of facts; interpreters for the interpretation, analysis and classification of facts; theorists for the correlation of facts and deduction of their underlying principles; and organizations for the dissemination of facts and principles proved true.

The American Association of Clinical Research is the only organization in existence which has set its object on the systematic scientific investigation of the science and art of medicine, the systematization of medical experiences, for the purpose, first, of ascertaining what is true in the present practice of medicine and surgery, and, secondly, of advancing the

scientific practice of medicine and surgery on the basis of truth and not of whim.

Stevenson asks, in his *Virginibus Puerisque*, "How would you have people agree, when one is deaf and the other blind?" I say, by making them feel.

No one who is sane can deny facts. The American Association of Clinical Research accepts records from whatever source, provided no question can be raised that they represent actual clinical phenomena and contain the original data. The data are examined, analyzed, correlated, and the facts and the principles deduced from them are disseminated, irrespective of whether they strike the deaf or excite the blind, for the aim is to stop the greatest scandal of the medical ages, the chaos and inertia of mere empiricism, and to place in its stead the fertile principles of rational, scientific medicine.

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### NASAL OBSTRUCTION.

WM. M. HILLEGAS, M. D., PHILADELPHIA, PA.

(Read before the Philadelphia Society for Clinical Research.)

How little one realizes, until the attempt is made to enumerate them, the number of causes of nasal obstruction. How rare it is to find a perfectly formed normal nose. I have contracted the habit of making an examination of the nasal passages of my eye patients, partly to try to find a normal nose, and also because sinus disease and nasal obstruction are so frequently the cause of eye symptoms, both inflammatory and neuralgic.

However, the presence of a deflected septum, or enlarged turbinates is not an indication, *per se*, for any interference, operative, or otherwise, unless there is present nasal obstruction of sufficient degree to interfere with the proper passage of air through the nostrils, and the production of the consequent symptoms.

These symptoms vary with each case, and embrace the following: stoppage of breath; mouth breathing, especially in children; necessity of sleeping with mouth open; snoring, aching across the bridge of the nose; sense of pressure in the nose; headache and eyeache; neuralgic pains in face; general retardation of development, especially in children, causing a stupid ex-



pression and sluggish mentality; catarrhal symptoms of discharge, and so-called "fresh colds," which generally are merely an aggravation of an intumescent rhinitis; sneezing attacks, also hay fever and asthma. I have even seen an irritable stomach, associated with vomiting, caused by nasal constriction, as proven by its cure on the removal of a bunch of polypi. The cause of these symptoms is either by direct pressure or reflex irritation through the nervous system, or imperfect carbonization of the respired air.

In the very young, nasal obstruction is usually caused by an overgrowth of adenoid tissue, associated frequently, but not necessarily, with enlargement of the tonsils. Later in life, septal deviations, and septal spurs are the most prolific causes, various authors quoting from 50 per cent. to 90 per cent. of deviations of some degree as being present in adult life. These and enlarged turbinates, I shall discuss later. Other causes of nasal obstruction are: polypi; syphilitic granulations; œzena crusts. As a result of sinus disease, granulations, or more frequently, a general swelling of all the soft tissues of the nose occurs, due to capillary engorgement. Foreign bodies, especially in children; these if allowed to remain in for any length of time become covered with thick mucus, which becomes adherent to the proximate tissues, and are then rather difficult of diagnosis. If you find one nasal passage clogged with adherent mucus, with mucopurulent discharge, and the other side quite clear, suspect a foreign body.

The inferior and the middle turbinates are the most frequently enlarged, the superior less often. An enlargement of the middle turbinate causes more symptoms than if the lower turbinate is swollen, as there is less room, and it is the middle turbinate that when enlarged obstructs the entrances to the accessory sinuses of the nose, and frequently causes sinus abscess. The swelling of a turbinate at first is a hypertrophy, with engorgement of the blood vessels; if of long standing this may and often does become a true hyperplasia, with increase of connective tissue.

Septal deviations, forming the bulk of cases of nasal obstruction in adults, and older children, are of the greatest interest. Septal deflection does not become marked in early childhood. A knowledge of the anatomy and development of the septal cartilage is of vast importance in understanding the causation of these septal deviations, but rather too long to detail here.

(You can find these in detail in Deaver's Regional Anatomy, Vol. I, page 108.)

The causes of septal deviation are: Congenital, developmental, and traumatic. The congenital are really traumatic also, being caused during delivery, or due to pressure in utero, although facial and family characteristics must not be overlooked. Developmental causes are usually due to a high palatal arch, causing an unequal pressure, and so doubling up the septum. It is quite possible for serious injury to occur to the septum, without any marked evidence of deformity or contusion, and falls are of daily occurrence among children learning to walk; this injury may be merely a bending of the septum, starting a subacute inflammation of the perichondrium, resulting later in hypertrophic changes, and a gradual deflection in the line of least resistance, or in the production of ridges or spurs. Septal deviations and deflections are found in all forms imaginable, from that of a pure deflection of the cartilage to one side, to the most twisted shapes. One side may be straight, and the other thickened, with ridges, or with one large concavity. Associated with septal deflections there are usually found more or less marked enlargements of the turbinates on the side of the concavity, nature's attempt to equalize the calibre of the air passages.

A pretty exact knowledge of the anatomy of the nose, and its development, as well as the clinical peculiarities of the varieties of obstruction, is necessary to make an accurate diagnosis in cases of nasal obstruction, and to determine the method of treatment best adapted to the individual case.

In the line of preventive treatment, I would strongly insist on the treatment of all colds, both by examination and prescription; the correction of all minor changes in the nasal mucosa; and the care of trivial injuries to the nose in childhood.

Excessive adenoid tissue must be removed by the knife. Polypi should be removed with a snare, and the base cauterized. Remove foreign bodies with warm saline spray and forceps.

In the treatment of enlarged turbinates, distinction must be made between hypertrophy and hyperplasia, the former, being merely a turgescence of the tissue as shown by the fact that it will shrink materially when a strong (10 to 12 per cent.) solution of cocaine is applied, can often be reduced by local treat-



ment with astringents and the use of internal remedies, or if these fail, by the use of the actual cautery, preferably by deep linear scarifications, which cause shrinkage from contraction, without much loss of tissue. Acids should be used but rarely, as they are less easily controlled than a cautery knife. A true overgrowth of tissue in the turbinates, a hyperplasia, can only be reduced by using scissors or snare, or both.

In the treatment of swellings due to sinus disease, the use of argyrol tampons, as advocated by Dr. Dowling, of Albany, is of excellent service. These tampons, saturated with a 10 per cent. aqueous solution of argyrol, are allowed to remain in place for 10 to 20 minutes, then the passage is douched with an alkaline solution, before the patient leaves the office. These are of especial service if there is a staphylococcic infection of the nasal passage or of a sinus.

Local treatment, of course, has no effect in correcting septal deviations, from the very nature of the condition, they being overgrowths, rarely bony, usually cartilaginous. In early childhood, the orthodontist may be called in to spread the superior maxillæ, and so lower a high palatal arch, thereby providing sufficient space for the growing septum. The saw is now but rarely used, except if there is a frank spur, with no deflection of the septum, a rather rare condition. The operation of choice must be one of the various methods of submucous resection, under cocaine anæsthesia, a comparatively painless and a clean operation, leaving no raw spots, in the nasal passages.

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ON THE INJECTION OF DRUGS, ESPECIALLY OF SALVARSAN (EHRlich) INTO THE LUMBAR MUSCLES.—S. J. Meltzer (*Medical Record*, March 25, 1911) declares that the sacrospinal muscle presents anatomically an exceptionally well isolated large compact mass, densely packed with fine muscle bundles. Any solution or suspension injected strictly into this mass will remain there and not affect locally the adjacent tissues. Experimentally it was shown that the absorption from this muscle is superior to that from the gluteal muscles and vastly superior to that from the subcutaneous tissue, clinically it was established in a limited number of cases of syphilis that salvarsan injected into this muscle exerts a fairly rapid, unmistakably beneficial influence upon secondary and tertiary manifestations of syphilis and upon the Wassermann reaction, without causing pain or other ill effects deserving serious considerations. He believes that the lumbar method deserves a critical trial by careful observers for salvarsan as well as for other drugs.

## Transactions of the Homoeopathic Medical Society of the State of Pennsylvania

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### BUREAU OF MATERIA MEDICA

WILLIAM H. YEAGER, M. D., Chairman

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#### THOUGHTS ON MATERIA MEDICA.

BY A. P. BOWIE, M. D., UNIONTOWN, PA.

To write an acceptable article for this Society one should be an expert or specialist on the subject upon which he writes. To practice homœopathy successfully one needs to constantly read and study its literature and especially the materia medica. While we read a great deal about the wonderful advance in medicine these days we need to recollect that the greatest advance in medicine ever made was when Samuel Hahnemann announced his discovery over one hundred years ago and gave to the profession of medicine his great works, "The Organon," "Materia Medica Pura" and "Chronic Diseases." These works must ever remain the classics of medicine and while rejected by the majority of the profession (although practically adopted in a covert way), it behooves us to maintain our rights as in the van of medical progress.

Had there been no truths in the doctrines of Hahnemann, those who rejected his writings would have let him alone, but I think the attitude they have assumed towards him and his doctrines is because they made the mistake of their lives in not allowing Hahneman to teach them how to heal the sick.

What means all the opposition that we have had to contend with, but that we have met the fate of all pioneers and by practical experiment proved our claims to be true at the bedside. When Hahnemann announced his discovery medical chaos reigned supreme, but he gave us a guiding principle in the selection of a remedy and a new materia medica. The latter work was a most radical departure from all previous works on the subject, for it consisted of a list of symptoms observed on the healthy, obtained by provings and in accidental cases of poison-



ing. This work must ever remain the standard one of pure drug pathogenesis and the drugs there presented to us have stood the test when applied at the bedside in healing the sick. No one but a profound thinker and a willing and painstaking worker could produce such a work, and that student or doctor of medicine who has not read this work should do so and profit by its teachings.

And yet there are other works that merit our attention, for our shelves are loaded with works on *materia medica*—from Hahnemann to Pearce—the latest. How to choose from them all is what puzzles the student. Clark in his dictionary on *materia medica* says, “When we consider that *materia medica* is the very *raison d’être* of the homœopathist, and that in it he must live and move and have his being, it is not too much to expect of him that he shall at least give as much mind to its cultivation as is required for maintaining high proficiency in golf and billiards,” and, may I add, in base ball.

What I may have to say on *materia medica* may seem commonplace to most of you and yet we need to have our attention focused on this subject if we are true to our calling. For why do we call ourselves homœopaths or why do we have our homœopathic societies or our homœopathic medical colleges except to teach, learn and practice all there is to be said on the subject. Let us be true to our principles. All the progress we have made heretofore has been accomplished by those who maintain our principles strictly, in spite of all opposition. All honor to our pioneers, let us follow their example and work and practice as they worked.

Is it not amusing to see the changed attitude of the regulars in regard to homœopathy? They are trying with all their arts to have us join their societies and some of our weak-kneed doctors have succumbed. The cure for all such secessions is the thorough teaching and study of our *materia medica*. When one looks over the long list of chairs and studies that comprise the curriculum of our modern medical colleges is it any wonder that the student has little time to devote to this branch of medical education, *materia medica*. And yet that is the most important thing to know thoroughly if one is to be a healer of the sick. It should be a profound cause for rejoicing that the oldest homœopathic medical college, and that one in our own State, has an endowed chair of Homœopathic *Materia Medica* and Therapeutics in memory of the greatest American homœopath,

Constantine Hering. No son could more gracefully perpetuate the memory of his father than Walter E. Hering has done, to make permanent his life work. We should all feel a debt of gratitude that in the great State of Pennsylvania we are able to record such generosity and may we all appreciate this gift as it deserves. And when those of the old school become dissatisfied with their treatment let them seek this medical Mecca where the true relation of drugs to diseases is taught, as well as all the collateral branches of medical science.

Homœopathy is not dying out as some would make us believe; it is a very live corpse and this endowment should be an incentive to others to do likewise.

Our list of works on *materia medica* is a large one, but it should be larger, for every physician should write on the subject; not to criticise only, but to make plain the selection of the remedy in every case we are called upon to treat; thus only will we reach perfection in our art and build into the temple of medicine the stone that was rejected by the profession at large but adopted by us.

In the early part of my medical career, two works were of great value to me and served to initiate me into the mysteries of the true healing art, namely, Hemple's *Materia Medica* Lectures, second edition, and Lippe's *Materia Medica*. One gave the remedies in extenso and the other the skeleton; each a supplement to the other.

No one can read the eloquent introductory lectures of Dr. Hemple without feeling inspired by his theme, and while we may not agree with all he says, no one will dispute that he deserves the greatest credit for making plain the practical application of our remedies, although had he treated every remedy as fully as aconite it would have required many more volumes to complete the work.

His description of the drug picture of aconite is certainly masterful. He calls it the backbone of our *materia medica*, and it has been said of him that he could accomplish more with this remedy and make more brilliant cures than any other practitioner of our school. In my own experience, aconite has a much larger sphere of action than is usually given it; it is especially useful in nervous conditions and congestions. Fever is but a small part of its curative sphere.

In Lippe's *Materia Medica* we have the characteristic symptoms of all of our leading remedies without comment. The



modalities are given and it has been said the basis of the work was Boenninghausen. As a ready reference work it serves me well.

Another work I esteem very highly is Hering's Condensed *Materia Medica*. It is a wonderful work and I have found it very helpful.

Allen's works are very useful and he certainly labored hard to make our knowledge of *materia medica* available. His *Primer*, *Hand Book*, and *Encyclopedia* are a monument to his genius and should have a place in every homœopath's library.

His *Hand Book* is very valuable, containing as it does a condensation of the *Encyclopedia*. The clinical feature of this work is very helpful.

Another book that has helped me is the work of Farrington on clinical *materia medica*. His comparisons are models and no one can take up the work without benefit.

The *Dictionary of Materia Medica* of Clark is a very complete work and shows painstaking labor in compiling it. His comments on each remedy are invaluable as showing their sphere of action.

The *Guiding Symptoms of the Materia Medica* by Hering is a wonderful work and shows how accurate and painstaking he was, to record all the symptoms of our drugs and especially to collect the clinical data pertaining thereto. He was a worthy successor to Hahnemann, and may truly be called the Hahnemann of America.

Numerous other works I could mention, more or less valuable, for the list is a long one and for this we should be proud, for is not our *materia medica* our main contribution to medical science?

If one glances over the literature of the old school since Hahnemann's time, especially of late years, many of their indications for the use of remedies have been taken from our *materia medica*. The works of Ringer and Phillips are notable for this. Let us keep working in this field, it is our own proper sphere. "Read, mark, learn and inwardly digest" should be our motto in this work.

In 1869 Richard Hughes wrote, in the closing pages of his work on therapeutics, thus, "During the sixty years since the establishment of '*Similia Similibus Curanter*' as the guide to specific medication, at least eight-tenths of the ill's flesh is heir to have been brought under its range of action. Of the two-

tenths which remain, one consists of mechanical disorders requiring mechanical assistance and the other is only awaiting fresh knowledge of diseases and drugs on our part for its annexation." These are the words of a true homœopath and in it there is no hankering after the flesh pots of allopathy, but true medical progress must be followed on homœopathic lines.

Do not the latest discoveries in science prove the efficacy of the single remedy and the minimum dose? Yes, we have had left to us a rich heritage, let us make good use of it so we may merit the "well done" of the faithful disciple.

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### THE VALUE OF SPECIAL CHARACTERISTIC SYMPTOMS IN THE SELECTION OF OUR HOMOEOPATHIC REMEDY.

BY E. B. NASH, M. D.

THE subject assigned me is as old as Hahnemann's Organon, but is always an interesting one. At the risk of being charged with advertising my own books, I will say, that I have tried in my "How to Take the Case," and "Regional Leaders," to give my views, yet it may not be uninteresting to review the subject in short here. The symptoms termed characteristics, as a guide to prescribing, must not take the place of what is termed the "totality" of symptoms, but be considered co-workers together with them. As to which should take precedence, there is great difference of opinion. In my own opinion I should say, that where there is a paucity of characteristics in a case, the "totality" would lead, and vice-versa—but, as long as we have the two methods by which to prescribe, why reject either? To the expert in prescribing, the characteristic method is all he needs in the majority of ordinary cases of sickness. Having three or four strong leading symptoms further study of the case will generally confirm the choice to which they point (of course there are exceptions to this). For instance—having prominent great prostration, burning pains relieved by heat, all symptoms aggravated from 1 to 3 a. m. Arsenicum, as we well know, is the remedy, no matter what the disease or pathology of the case. All the polychrests have equally characteristic symptoms. Of course many remedies have great prostration, so this alone would not be very guiding. Many remedies



have burning pains, such as, phos. sulphur, cantharis, so also are the symptoms of many remedies relieved by heat—such as nux vomica, mag. phos., hepar sulph., and c. The midnight aggravations may occur under other remedies, but this combination is not found so prominent under any other remedy. This shows an element of totality that must come even into this kind of prescribing, but it is a much shorter road to the goal than what is called reportorial prescribing. In my own case, for instance, I think I may say without fear of being charged with boasting, that in a case well taken, I can predict a remedy that a more lengthy study of the case will confirm. This after a study and practice of fifty years duration. The coming into the field of materia medica work of the characteristic cards of Hering, followed by the keynotes of H. A. Guernsey, and the Therapeutic Hints of Charles G. Raue, marked an epoch in the progress of the practical development of our art of prescribing. All the real homœopaths sprang to the work, and the journals fairly bristled with cures confirming the truth of our three cardinal principles, First, the similar remedy; second, the single remedy, and third, the minimum dose.

Symptoms were estimated and accepted for what they did in the way of curing the sick, whether we could explain their action from a physiological or pathological standpoint or not. The clinical result oft-repeated settled it. *Similia similibus curanter* was the touchstone which was brought to test in all cases, and decided the genuineness of any clinical testimony. This kind of work is still being done by a minority in our school. We need a great revival along this line. Pathological research is now in the lead in our ranks, as well as in the old school of medicine, and is commendable as far as it goes, but we must remember that homœopathy is too large to be squeezed into this only pathological livery. The vital or life force of both patient and drug cannot be brought within the range of laboratory or bacteriological analysis. No such work can explain the why and wherefore of the stinging pains of apis, or the burnings of arsenicum and sulphur, or the stitching pains of bryonia and kali carbonicum nor can the many other sensations be explained, so also with the modalities of bryonia, pulsatilla and rhus tox. No provings reported ever produced the germs of intermittent fever, diphtheria or tuberculosis. Abundant observation and experience has demonstrated that we can, by the application of the symptomatically indi-

cated remedy, either prevent or cure the diseases in which they occur. Who can explain the milk-white tongue of antimonium crude; the yellow-coated at the base-tongue of merc.-protiod; or the dry triangular red-tipped tongue of rhus tox.; or the flabby-tooth-indented tongue of merc. vir or sol. That there are many pathological or subjective symptoms, as in the œdema of apis, the various stools which are characteristic, with the sensations and modalities, goes without saying, nor can they always be explained, but must be accepted and utilized, but they have been and are capable of being produced in provings.

We cannot spend much more time along this line, in a fifteen minute paper, but enough has been said to suggest three things: First, that in the symptomatology of our well proven remedies, we have a reliable guide for the application of them to the cure of the sick. Second, that those symptoms termed by Hahnemann peculiar and characteristic, are of first importance. Third, that what Jahr calls the tout ensemble or totality, will corroborate the correctness of the choice so made. In conclusion I would recommend the student to begin the study of materia medica by mastering such works as H. C. Allen's Key-notes, my own Regional Leaders—as introduction to the more extensive study of the ten volume works of T. F. Allen, or Hering's Guiding Symptoms.

Hoping to have suggested some thoughts for discussion in this necessarily short paper I will close.

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### DOES THE TOPICAL APPLICATION OF DRUGS TO SKIN LESIONS INTERFERE WITH THE ACTION OF POTENTIZED MEDICINE?

BY RALPH BERNSTEIN, M. D., PHILADELPHIA, PA.

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In attempting to answer this question I shall base my statements purely upon scientific deductions. I shall not deal with hypotheses, or conjectures, or presumptions of the past, but will merely try to picture and demonstrate those essentials which this modern age of ours,—in which we want to be shown all things conclusively and definitely,—have made possible.



Naturally the question as to whether the topical application of drugs interferes with the action of potentized remedies divides itself into two propositions the first one of which refers to the absorptibility of the skin as to various substances applied upon it; and, secondly, as to whether it is possible to drive an eruption in by the application of drugs upon the skin.

Now, then, does this second proposition actually enter into the discussion? Yes, it does, because if the topical application of drugs in diseased skin conditions really does drive in the eruption, then surely it must interfere with the action of the selected remedy because it must certainly change or alter the entire systemic condition for which the indicated potentized remedy was administered.

Let us proceed then to a discussion of this all important question, and let us decide as to whether the topical application of drugs really does or does not interfere with the action of the potentized remedies, and having thus decided, let us hold our peace forever.

Now let us first consider—does the application of local drugs drive the eruption in, and thus interfere with the action of the potentized remedy? No lesser authority than the great savant of one hundred years ago, our own Samuel Hahnemann, speaks time and time again, when referring to topical applications, of “driving the eruption away,” never in. Unna agrees with him, and so does Duhring, and so does Hebra and Croker as well, and a great host of others. Surely they ought to know.

Nor is it possible to drive an eruption in by too quickly healing it by the topical application of drugs. Yet there are authorities who contend that such is a possibility; for instance, Feer, in the *Correspondenzblatt für Schweizer Aerzte*, reports eight cases in which children died after the apparent cure of eczema. Butte, in the *Ann. de Ther. Derm. et Syph.*, reports two fatal cases of death following eczema. D. Amato, in the *Mon. f. prakt. Derm.*, agrees with the two foregoing authorities, contending that there is a reciprocal relationship between the toxic elimination through the skin and the internal organs.

This, however, has nothing whatsoever to do with the fact of the eruption being driven in, because nature itself had seen fit to absorb its own toxic products which it had in vain tried to get rid of through the skin.. It is worthy of note that among the cases reported the cause of death was pleurisy, bronchial

pneumonia, asthma, gout, rheumatism, etc., and in several cases reported no demonstrable cause of death could be given.

Now, again, these opinions are not based on scientific data. They are merely presumptions. Feer, in the cases which he reports of death following the cure of eczema, presumes that these children died after the cure of eczema. It is perfectly plausible for them to die after the cure of eczema. That does not say they would not have died while they had their eczema or previous to their having it. No deduction as to the exact cause of death is given.

Now there is no doubt but what it is perfectly safe to presume that these authorities may possibly have been mistaken in the conclusions which they have drawn, nor is it not possible that eczema may have been coincident in these cases? And because they were cured by topical applications, should said applications be blamed for driving the eruption in and thereby causing death when other causal evidences of death were present? And then again, are not people dying every day in whom frequently no demonstrable cause of death can be found?

Now how can the diseased condition be driven in because of the statement which I have previously made, and that is that the diseased condition itself being in an abnormal state does not reverse itself, disappearing in an apparent cure, and then attack some internal organ, except, of course, in cases of malignant disease. (These are facts, not fancies, these are certainties, not presumptions.)

There are all sorts of cases reported attempting to show a relationship between suppressed skin diseases and internal disorders. For instance, Burnett presumes that a patient who was supposed to have had angina pectoris following the cure of a mild attack of eczema appearing in the flexure of one elbow, that this skin condition had never been really cured, only driven in by the famous Erasmus Wilson, and that her angina was in reality the expression of her external condition. To quote from Burnett, he further states that he began to treat the angina, which he contends she never had, when lo and behold the old cracks appeared in the bends of the elbows, and from that time on she had no further attacks of angina.

Case No. 2. Eczema capitis suppressed. Fatal issue. About nine years ago the wife of a staff officer brought her bonny little boy to me, Dr. Burnett said. "He had the milk crust



scalp; in fact, he had crusta lactea, the scalp appearing one solid crust of scabs; but the child seemed perfectly well and joyful."

I prescribed for the child constitutionally, and forbade all local treatment. The lady's father, however, who was a retired physician of repute, and who was staying with her, seeing the child's eczema, told the mother to use an ointment for the scalp. She told her father my warning not to put anything on the bad head but the old gentleman over-ruled and prescribed ungt. zinci, which soon healed the eczema. A fortnight later I was suddenly called by telegram to come at once as the child had been seized with convulsions. The local doctors were all non-plused. I did my best to get the eczema back on the surface of the scalp, but totally failed. The child died, and the grandfather, sobbingly, said: "Oh! you zinc ointment."

If the frenzied grandfather was still alive I should think, in this scientific age of ours, we could quickly calm and soothe his sobbing breast, and say to him: Have no fear, because it was not the cause of your grandchild's death. And surely, how could it have been?

Here again is proof positive of the fact that the zinc ointment applied, purely an inert substance, had no influence upon driving the eczema in or upon the child's death, and will bear out the statements to follow; the baby's resulting death from convulsions having no doubt been due to some other condition.

I cannot possibly see how an eruption could be driven in by a topical application or in any other way. I shall later on demonstrate an attempt to show conclusively that a mild and soothing topical application time and time again assists the action of the indicated remedy most remarkably.

We do occasionally hear a frantic mother appealing to the nurse or physician to bring out the eruption because it has disappeared, and the mother frantically cries: "The eruption has been driven in," and is looking for a terrible end for the patient.

If we stop to think but a moment that perhaps it was the room which had become suddenly cooled, or the patient had carelessly thrown off the covers in delirium or restlessness, one can readily realize that then it must have been the cutaneous circulation which has been decreased because of the sudden cooling of the patient, which has caused the apparent disappearance of the rash. Just as quickly as the room is again warm, and the patient is brought back to normal condition, just as

quickly then does the rash reappear; showing it to be an absolute fallacy to think for a moment that the disease or rash could possibly be driven inward, because we must thoroughly realize from scientific facts and observations that the vasomotor system controls dilation and contraction, stimulated by the presence of circulating toxins or otherwise, which is responsible for the manifestations of cutaneous disease.

Therefore, does the topical application of drugs interfere with the action of potentized remedies? Let us not stop to consider the answer now; but let us go on to a consideration of the question of the absorptibility of the skin, because a consideration of this part of our proposition bears more than an important relationship to the answer of the question as propounded by our worthy chairman.

Then to begin: "The epidermis forms practically an impermeable barrier to the absorption of liquids and solid substances." Stelwagon. "Its absorptive qualities are negative."—Pusey. "The absorptive power is generally slight, more so than is even supposed."—Kaposi. "The corneous layers of the epidermis are almost impervious to liquids and finely divided solid substances."—Fleischer. "The naturally lubricated, firm, horny layers of the epidermis offers the chief obstruction to absorption by the skin."—Dearborn.

Therefore, we can reasonably and safely say that the skin is practically non-absorptive, except to certain substances and under certain conditions. Mercury, arsenic, iodine, tar and sulphur are, however, more or less absorbable by the skin, especially under certain conditions mercury perhaps being the most absorbable of all, it being contended that the mercurials undergo vaporization, it being a well known fact that gases or vapors are more readily absorbed than other substances.

Now when we use mercury in the treatment of syphilitic affections surely we direct the patient to rub it in good and hard until it entirely disappears. With the infant with the sensitive and tender skin we apply it upon a binder, and thus by friction the substance is more readily absorbed.

Would the application locally of mercury in the treatment of syphilis interfere with the action of the potentized mercury internally administered? Hahnemann, in the "*Organon*," states: "The remedy used externally must also be the only one that is useful when administered internally." Therefore does the local application of mercury in this condition interfere with

the action of potentized mercury internally? The answer is obvious, and I need not longer linger, so let us proceed.

Now then, with reference to arsenic, sulphur, iodine and tar, surely if these remedies should happen to be indicated in their potentized form, why then should they not be used locally for the same reason that mercury can as well be used locally and internally according to the doctrines of Hahnemann?

So far I have referred entirely to the non-absorptibility of the unbroken skin; in other words, where there is a lack of solution of continuity. However, when this once takes place, where we have perhaps a small or large area of intensely inflamed exuding areas of epidermis, who would think for a moment of rubbing in unguentous substances upon such a diseased surface? Surely, in the first place, the patient would not permit it because of the intolerable pain it would produce. Surely able physicians never advise their patients to rub in any ointment or lotion upon such an inflamed surface, nor do they advise any such procedure upon any acutely inflamed area such as erythemas, etc., even without a lack of solution of continuity.

Again, the diseased state or condition of the skin makes it such that its normal functions are nil or at a stand still, and instead of a tendency to want to absorb, they are excreting, pouring out volumes of serum and what not from their diseased glandular orifices. Therefore, there is no absorption because, as has been previously stated, absorption only takes place with certain substances under thorough friction (referring to mercury); and surely the substances already elucidated, mark you, are never, never used in acutely inflamed areas with either broken or unbroken skin.

Now then, such substances as boric acid, calamine, zinc oxide, glycerine, lime water, petroleum, lanoline, olive oil, goose grease, etc., are applied. Mark you, they are not absorbable without friction. They merely act as a protecting covering to the skin; in other words, they protect it from the atmosphere; they soothe and calm the exposed sensitive nerve fibrils, and in that way subdue irritated, highly inflamed epidermis, causing the internal potentized remedies to have all the more of an opportunity to assist in their errands of amelioration and mercy. Now then, so far; does the topical application of drugs interfere with the action of potentized remedies? Well, let us go on.

Now it has been demonstrated scientifically and beyond the



shadow of a doubt by the clinicians of Vienna, and verified by my own experiments as well, that pigments incorporated in certain oils and ointment bases, and thoroughly rubbed into the skins of cats, rabbits and dogs for a certain definite period of time, sections of skin then made and studied beneath the microscope, it was found that lanoline, always having enjoyed the reputation of being the most absorbable of all ointment bases, together with petroleum, hardly penetrated deeper than the narrow constricted necks of the skin follicles, while goose grease, olive oil and almond oil in their order were found to have penetrated beneath the necks of the follicles; the goose grease being the most penetrating of all, going far down into the very bulbs of the follicles and, mark you, all of these under persistent rubbing.

Then, again, these very substances incorporated with pigments and applied to the skin without friction for definite periods of time were found to have been absolutely non-absorbable at all. These are scientific facts not based on hypotheses, not based on deductions, not based on presumptions, but clean, clear-cut facts to which there is no argument.

Again, it is presumed that if substances are to be absorbed by the skin they must be in finely divided, minute particles, and surely the way the majority of ointments are prepared and put upon the market they are far from being in any such admirable state of perfection as just mentioned.

Now then, with reference to the more chronic dermatoses such as hard, indurated types of eczema, for instance lichen, psoriasis, etc., where the physician is wont to direct his patient to rub the ointment in long and well because he wants its stimulative effect upon the skin, surely he usually uses lanoline or petroleum as his ointment base. As aforesaid, I have demonstrated that these two ointment bases of all ointment bases are not absorbable. So, therefore, again; does the topical application of drugs in these or in any other type of dermatose interfere with the action of potentized remedies?

Once more, we have seen by clinical observation in several series of cases treated in the various dispensaries and hospitals with which I am connected that side by side those dermatoses which were assisted by the topical application of mild, un-irritating substances, co-associated with the administration of the indicated remedy, made much more rapid progress, gave quicker amelioration, exerted a much more rapid soothing and

calming effect than those series of cases treated on the indicated remedy alone.

#### DISCUSSION.

DR. E. M. GRAMM: The teachings that have come down to us from Hahnemann are that, the local application of remedies has a tendency to suppress skin diseases and to interfere with the action of the homœopathic remedy. Our older physicians, carried out by that idea, tell us of all sorts of dire consequences that they have seen occur when an ointment or lotion was applied locally to a skin disease. We were taught, too, in former days that the skin was a sort of dumping ground on which the system throws the products of disease. Just how that line of reasoning could be followed out to prove that a patient who has gall stones, for instance, would have this condition finally vent itself upon the skin, is rather difficult for me to understand. Dr. Bernstein has well said that the outer layers of the epidermis are non-absorptive. When the rete mucosum, where we find the beginnings of the lymphatic system is uncovered, absorption is very possible.

In considering the question of whether remedies applied to the skin can interfere with the indicated homœopathic remedy given internally, we have to take into consideration the relationship of remedies. We will grant that a remedy has been placed on a surface on which the rete mucosum is exposed, and on that account the ultimate intercellular beginnings of the lymphatic system have been enabled to take up some of the remedy applied: it goes without saying that the remedy, if absorbed, will have precisely the same effect as a remedy which enters the system from having been given by the mouth or any other way. It must act either inimically, antidotally, complementarily, or we can imagine that there are remedies which are inert when given with or following a certain other remedy. We have then three ways in which remedies can act. If an antidotal remedy is absorbed by the skin, there is no doubt but that it would undo the effect of the remedy we had given by the mouth. If an inimical remedy is absorbed by the skin, it would unquestionably alter the effect of the remedy administered by the mouth. If it were a remedy that would act complementarily, it must help the cure; so that you see, we cannot approach this subject arbitrarily and say that,—no matter what medicinal substance you apply to the skin or how you put it on, it is always injurious.

DR. BOWIE: I do not care to use any specious reasoning to prove anything. Let experience prove the facts and let the facts

be our guide in the future. I just want to mention one case: A man came to me a few years ago with dropsical symptoms. He was edematous from his feet to his diaphragm, short of breath and had a cough. I inquired of him what preceded this trouble. He said that he had had an eruption on his legs below the knees, very red and fiery and that a doctor had applied an external application to it. This application allayed the eruption and the redness disappeared; but after it disappeared the dropsy began. I selected a remedy for him very carefully, and the remedy that I gave him was arsenicum, which was taken, and after a certain length of time, the swelling commenced to go away and the eruption appeared again on his legs. No other remedy was given. I think that Hahnemann knew what he was talking about; and if there is one thing that I believe, it is that the suppression of a skin disease does lead to bad results. I treat all of my skin diseases with internal medication and use no applications. I think it is a heresy in homœopathic circles to advocate the suppression of any kind of an eruption with an external application.

DR. MILLER: I can readily understand how men who make a specialty of skin diseases like to justify themselves, and yet I cannot understand when they stand up here and tell us that the skin is an absorbing organ, why they use those applications. If the disease is a local disease, and the remedy they put upon the skin acts as a curative agent, there is no use giving internal remedy. I believe that Hahnemann knew what he was talking about, and when the doctor said that Hahnemann states it was "driven away," he simply is begging the question. Where could it be driven to if not internally? I believe that every man who has had experience, has had evidence presented to him sufficient to convince him that there is such a thing as the suppression of skin disease by local applications. We know that, after the applications are applied, skin manifestations disappear and dire results follow their disappearance. I would like to present to you the history of two cases:

Case I: A woman came to me who had an eczematous eruption on the chest. This eruption disappeared upon the application of a local remedy and the result was from that time on she has had asthma.

Case II: A child had eczema capitis, and zinc ointment was applied. After that the eczema disappeared from the head and the child fell into a comatose state. The mother brought it to me and wanted to know what was the trouble. After I had gotten the history of the case, I told her that I believed that the child would get better if we could reproduce the eruption.



With treatment the eruption reappeared and the child regained consciousness.

DR. BERNSTEIN: How long after the eruption disappeared did the child go into a comatose condition?

DR. MILLER: The child was almost unconscious for several weeks. The mother stated that the coma developed after the disappearance of the eruption. Another case that I know of was a child who was being doped by the external applications that the skin did not absorb, was thrown into convulsions and these convulsions continued until the external applications were stopped; then the child got well.

Now, about inunctions: The old school people have taught that inunctions of mercury are a sure cure for syphilis; but the doctor tells us that you have to rub in vigorously or it is no good. If this is true, I would like to know how remedies applied to the skin act. If they are not absorbed, they are certainly not under the influence of the vaso-motor system; they are not under the influence of the nervous system or under that of any of the reacting forces that make for life.

Now! If there is anything in Hahnemann's idea, there is something in the psoric theory. I believe in the psoric theory of disease, and I believe that there is such a thing as a metastasis of disease from one organ to another. Naturally the manifestations of disease are different in different tissues, for example: When it manifests itself on the skin it may be in the form of eczema, when on the mucous membrane of the bronchial tubes, it may be asthma, it may be a chronic diarrhoea or Bright's disease or any of those diseases that we have fought so long and cannot cure. I also believe that when nature is kind enough to the patient to place his ailments on that portion of his anatomy where it will do him the least harm, that it is the business of the medical profession not to interfere with that by local applications.

DR. POND: In prescribing local applications for the skin we are not attempting to suppress skin disease at all. One of the chief effects that we desire to produce is, that of protecting and soothing the skin. Other applications are germicidal, and anything that prevents the bad effects of the germs on the skin, cannot but be beneficial. I have not in my experience been able to satisfy myself that I have ever been able to suppress a case of skin disease. If it could be positively shown that local applications were without effect, I would be very glad to discontinue them.

DR. EDMUNDSON: In my experience of four years in private hospital practice, I have found that the local application of

sulphur has resulted disastrously in a considerable number of cases. I could recall a large number of cases of eczema capitis, in which convulsions, diarrhœa and various other troubles followed the application of sulphur ointment. Under proper treatment the eczema would reappear and the patient would get well.

DR. FLEAGLE: There seems to be a good deal of discussion as to whether the skin is capable of absorbing medicines applied to it. I have had an experience that bears upon this point: Some years ago an epidemic of grippe occurred in our neighborhood, and many people put sulphur in the soles of their shoes to keep them from getting the grippe; a great many developed symptoms of sulphur poisoning. Persons who wore silver finger rings noticed that they turned black. If the sulphur was absorbed from the soles of the feet, it is just as reasonable to suppose that arsenic and other remedies can be absorbed just as easily. All of you have seen chronic diseases develop after suppression of an eruption. I have seen tuberculosis develop after a fistula was cured; I have seen arthritis develop after the suppression of gonorrhœa by injections. This is only analogy, understand; but it shows one thing, that Hahnemann was correct when he stated that external applications do affect the action of internal remedy. Hahnemann's dictum has stood the test of time. The theories of those that opposed him have fallen.

DR. HEIMBACH: A case has recently come under my observation in which rheumatic pains followed the suppression of a rash. Administration of sulphur caused the rash to reappear and the rheumatic pains subsided.

There is undoubtedly, a relation between the skin and the internal organs that we do not fully understand; but it is probable that the skin eliminates some poisonous substances that may produce internal disease if driven in.

DR. GAY: There has been a good deal of talk about the relation between eczema and dropsy. I have observed that many patients suffering with uric acid and other forms of toxemia will have local manifestations of varying character. One time the patient may have a cough and another time asthma, and again skin eruptions, etc. It does not follow because local application has been applied to the skin, that the other manifestations appear as a result.

DR. THEODORE GRAMM: I think it is our duty to try to settle this question by making accurate observations on our cases. I would like to make a plea, when it comes to the practice of medical therapeutics, that we apply the same methods of careful and accurate observation, that are used in surgery and other departments of medicine.

DR. BROOKS: I believe that in a direct injury or contusion, a local application will bring good results along with internal remedy. I have used saxonita as a remedy in lacerations and contusions not only local but internal with good results.

DR. T. J. GRAMM: I want to say that my confidence in my belief in the truth of the principles of homœopathy is so deeply seated and so complete that I am almost on the point of taking offence when it is assailed. One of the most unfortunate things in the practice of medicine is the confusion of the "Post Hoc" with the "Propter Hoc;" the trouble is that men regard these occurrences as matters of opinion.

DR. BERNSTEIN: In closing this discussion I would merely reiterate the fact that the conclusions reached were based purely upon scientific laboratory methods and the results of clinical experience, and are not presumed to be mere hypotheses or conjectures of the past, the subject matter under discussion being "Does the Topical Application of Drugs Interfere with the Action of Potentized Remedies," and therefore all discussions which have referred to the relationship between internal diseases and skin disorders are irrelevant.

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## BUREAU OF SURGERY

G. B. MORELAND, M. D., Chairman

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### X-RAY TREATMENT OF DEEP-SEATED MALIGNANT CONDITIONS.

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IN presenting this paper, I offer very little that may be new or original, but I wish to emphasize certain features which have appealed to me in my therapeutic use of the X-Rays in deep malignant conditions, and call attention to the indications and limitations of their use. Much has been promulgated upon this subject and much has been claimed both wisely and unwisely. It is the misfortune of all new therapeutic measures to be boomed, at first, beyond all reason, then, in the natural recoil of opinion, to lose even the degree of credit they deserve. The therapeutic use of the X-Rays has been more extravagantly praised and more unjustly condemned than perhaps any other new therapeutic agent. At first, claimed by over enthusiastic operators as almost a specific for diseases heretofore considered incurable, or only curable by severe and dangerous



operations, it was applied by many who were incompetent intelligently to observe and regulate its effects; and not infrequently serious accidents have occurred and have had much to do in bringing the treatment into disrepute. Again, others not understanding its effects upon tissues, both physiological and pathological, have applied the treatment unadvisedly, and have obtained no beneficial results.

With these disappointing experiences, it was to a large extent thrown aside as entirely without therapeutic effect and dangerous to handle. To-day, among the surgeons, there is still a great difference of opinion in regard to the usefulness of X-Ray treatment of deep-seated malignant conditions, many holding that the treatment is absolutely useless if not harmful, others reserving it for post operative application, with the hope of preventing recurrences.

On the other hand, many surgeons of great experience who have utilized this form of treatment consider it a most valuable and extremely useful adjunct in the treatment of malignant growths; and in the treatment of non-operable conditions the only form of treatment offering any prospect of benefit.

In records furnished by operators of unquestioned integrity and skill, it has been clearly proven that the X-Ray does favorably influence a certain percentage of true carcinoma, and shows symptomatic cures in favorable cases of about 20 per cent.

In comparison with surgical results, I would cite the records of the Second Surgical Clinic, University of Vienna, which show the results of 520 cases of mammary cancer operated with permanent cures resulting in 12.5 per cent.

Another report by Steinthal summarizes 236 cases with 16 2-3 per cent. of cures. Other reports show about the same percentage, ranging from 10 per cent. to 18 per cent. Roswell Park, in a discussion of breast tumors, under the head of prognosis states:

"It must be admitted that the prognosis of operations done in the past for cancer of the breast have been most unfavorable. According to statistics, but a few months at most being added to the patient's life by operation. This fact has become so well understood by the laity that women suffering with cancer of the breast have preferred to let the disease take its

course rather than submit to a serious mutilating operation, which offered at best but a temporary respite."

In an editorial in the *Medical Record* of April 15, 1902, Dr. George T. Schrady states:

"We know our limitations in the radical surgery of carcinomatous diseases, and we recognize the fact that our best efforts do not cure, but only in a small proportion of cases annihilate the neoplasm."

Dr. A. J. Ochsner, of Chicago, who has collated reports of operated cases both with and without radiation, gives the following reports:

(a) Those treated by surgical means only give a percentage of 56 per cent. of recurrences in four years. The percentage of symptomatic cures in four years has been 27 per cent. Secondary operations for the removal of recurrences give a percentage of recurrences following such operations of 90 per cent., with a percentage of cures in four years of only 5 per cent.

(b) Those treated by both surgical methods and the X-Ray. Primary operations followed by immediate X-Ray treatment gives a percentage of cures in four years of 30 per cent. Secondary operations for the removal of recurrences, followed by immediate X-Ray treatment, have been apparently of about the same benefit.

Dr. Charles Leonard emphatically endorses the use of the X-Ray in these conditions, and advocates early removal by surgical means and application of the Rays at once, or as soon as the patient is able to be moved to the X-Ray room on a stretcher. He insists that at least 18 or 20 treatments should be given after all symptoms have cleared away. All his reports show the X-Rays to be a great supplement to operative work rather than a supplanter.

In considering the therapeutic application of X-Rays to deep-seated malignant conditions, an understanding of their physiological action as adapted to their treatment is essential, and I shall call attention only to those effects which are applicable to the treatment of the diseases under discussion.

Their first effect is that of stimulation, producing, in their less intense action, a proliferation of cell elements by division of the nuclei, and the formation of new cells. When this effect is intensified, over-stimulation is produced, with disorganization of the cells and their destruction by fatty degenera-

tion on necrosis. Upon the blood vessels, this destruction of the endothelial lining produces a curling up of the membrane, a plugging of the vessels with cells, an increase in fibrin, and finally, an obliterative endarteritis.

Upon the lymphatics, both vessels and glands, a peculiar action is manifested. The vessels become hard sclerosed bands, and the glands, small, hard, fibrous masses, with entire disappearance of glandular tissue. Connective tissue is changed into fibrous tissue by over stimulation of the cells with obliteration of their nuclei. This destructive action upon living cells destroys certain diseased cells before it destroys the more resistant healthy cells and stroma and theoretically gives their indication for therapeutic application in various malignant conditions.

The X-Rays have a depressent effect upon every kind of tissue. The rapidly proliferating cells of neoplasms are less resistant than the normal cells. The X-Rays are applied in doses from which the more susceptible diseased tissue cells cannot recover, but from which the neighboring sound tissue cells do recover after a period of depression. Where small repeated doses are employed the quantity applied is such that the sound cells completely recover from the effects of one application before the next one is made, while the neoplastic cells, more decidedly affected, do not completely recover between applications and experience accumulative effect. Although the healthy tissues surrounding the parts treated and exposed to the Rays suffer a lowered vitality for a short time, the reaction results in a stimulation of their nutrition and increase in resistance. Microscopic study of these morbid tissues after the Roentgen Ray treatment shows necrosis of the cancer cells and trabeculæ, at times a fatty degeneration, an increase of elastic tissue, and a tendency of the occlusion of vessels by a thickening of their inner walls, due to an endarteritis. To the latter effect is probably due the lessening of hemorrhage frequently noted in these cases after the treatment has been continued for some time.

The effect sought is not one of destruction *en masse*, but of molecular change and elimination. By destruction of the cell elements and consequent liberation of nuclei, there may occur a rapid accumulation of toxins, producing a degree of auto-intoxication which might prove serious unless the applications are discontinued for a time and the condition given appropriate



treatment. The fact that nearly every case treated by the X-Rays seems to improve in general physical health at the beginning of the treatment shows that they exert an influence which is not only local but also systemic.

From personal experience and observation of this class of cases under treatment, I have come to the conclusion that there is an increase in the general vitality of these patients due to a stimulating and tonic effect, and it has been surprising how rapidly some of them have lost their cachectic appearance and have gained in weight and strength, even when there has not been much noticeable effect upon the local condition. This beneficial action has, by some operators, been ascribed to the relief of pain; but the same effect has been noted in cases where the suffering was not of sufficient intensity to result in such debility. In many cases of cancer and sarcoma in which the position of the growth was such that it was impossible for it to have received enough radiation to have a direct effect the improvement has been decided. This is explained by the belief that a malignant growth undergoing X-Ray exposures sets free toxins, resulting, secondary, in the production of anti- and the raising of the opsonic index, culminating in a curative effect.

By most radio-therapeutists, sarcoma is believed to be more easily influenced by the X-Ray than carcinoma. The sarcoma resembles embryonal connective tissue, being rich in cells of round or spindle shape with a loose reticulum of fibres, a type of tissue which seems to be peculiarly susceptible to radiation.

If we admit that superficial malignant conditions are curable by radiation (and no one who has investigated this matter, unprejudiced, can doubt it, as it has been absolutely proven that the X-Ray does cure about 90 per cent. of such conditions), we cannot doubt that malignant conditions in any part of the body would be as amenable to this form of treatment; provided the same action can be brought to bear upon it, because cancer tissue is primarily the same in whatever part of the body it may be found. In the early use of this agent in the treatment of deep seated malignant conditions, frequent injurious effects to the derma and overlying structures was experienced. At present we can practically overcome such deleterious effects and bring the action of the Rays upon the deep rooted tissues without any or very little destructive action upon the superficial structures. This is accomplished by using Rays of deep

penetration, with the tube at a distance from the skin greater than that from the skin to the diseased tissue, because these Rays are less absorbed by the superficial tissues, and, being less absorbed, more are available for affecting the internal organs. The tube being at some distance from the skin, the soft Rays, or those of slight penetration, upon the absorption of which the injurious action upon the skin depends to a large extent, lose much of their effective power before reaching the surface. As an additional safeguard, the rays are passed through a filter of sole leather or thin aluminum which to large extent cuts out these rays. Judgment must also be used not to use rays of too high a penetration, which would pass through the morbid tissue without coming to rest in the growth, as it has been shown that the mere passing of the rays through such growths has a stimulating and not a destructive action, and may increase its proliferation.

In corroboration of the therapeutic effects of this form of treatment, I shall report a few cases in which the diagnosis was verified by microscopical examination of sections of the growth, or in which the conditions were so pathognomic that a mistake was practically impossible.

Miss X., aged 49, came under treatment June 3, 1908, with the following history: She had noticed a tumor in the left breast about two years previously, which had grown rapidly. The nipple and surrounding parts sloughed; there had been intense pain at times. For about six months previous to her presenting herself for treatment, she had been compelled to discontinue her occupation, that of a dry goods clerk, on account of extreme weakness. She had rapidly lost weight and was decidedly cachectic. During this time, on account of maidenly modesty, she had not consulted a physician in regard to her condition. A serious hemorrhage suddenly occurring, had so alarmed her that a physician was summoned who informed her that the disease had progressed to such an extent that it was inoperable and her only hope was in X-Ray treatment.

On examination, I found an ulcerated area about the original size of the breast, there seeming to be very little of the breast tissue remaining. There was a profuse bloody purulent discharge of extremely foul odor. The axilla was filled with an indurated mass and the left arm was much swollen. She was so debilitated that it was only with great difficulty that she could

get to my office. The first few applications markedly relieved the pain. The discharge gradually lessened and lost its foul odor. The ulceration began to heal about the borders until it had decreased to about one half of its original size; the swelling of the arm disappeared, and the mass in the axilla became somewhat smaller and softer. At this stage, in spite of vigorous rayings, the improvement in the local condition ceased. During this period of about three months' duration her general health and strength had improved remarkably and she gained about ten pounds in weight. She resumed her position as saleslady and continued at her employment for almost a year, still continuing the treatments. Suddenly she began to fail and after an acute illness of two weeks' duration she died of what appeared to be general systemic toxæmia. The beneficial results attributable to the Rays in this case were: complete removal of pain, apparent arrest of the disease, and tendency toward a reparative process, the cessation of discharge and hemorrhage, and the marked improvement in her general condition.

Mrs. McL., aged 50, carcinoma of left breast, had been under treatment for several months with the result of entire relief of pain and the lessening of the size of the tumor. Finally, not trusting the curative effects of X-Ray treatment alone, she decided to have it removed, and was operated at the Homeopathic Hospital by Dr. J. H. McClelland in June, 1908, and there has been no indication of recurrence.

Dr. F. S. Morris, the pathologist of the hospital, made a very careful microscopical examination of the tumor and reported that the entire breast had undergone fibrosis and showed no active cancerous tissue, except at one small spot in the center of the growth. Without doubt a further continuance of the treatment in this case would have resulted in an absolute cure.

Mrs. W., aged 83, carcinoma of right breast, referred by Dr. H. S. Nicholson, June 2, 1908, had noticed a tumor in the breast for several years which had given her very little trouble. For two or three months there had been a very rapid increase in size, with severe pain, and oozing of a bloody serum from the retracted nipple. On account of the patient's age, operation was considered inadvisable and she was referred for X-Ray treatment. Under the treatment the pain soon ceased, the oozing lessened, and her general health improved decidedly.



Radiation was continued, with three periods of intermission of about two months until July, 1910, when a dark, gangrenous looking spot appeared about the nipple. This enlarged until the entire tumor became gangrenous, loosened from the surrounding tissues, and was removed as a mass about the size of a small orange. The wound healed kindly and there is no appearance of recurrence. This effect was no doubt due to an obliterative endarteritis shutting off of the blood supply of the growth.

Mr. P., aged 62, admitted to the hospital November 1, 1908, had been suffering from a tumor on right side of the neck for about three years. For about three months had noticed an increasing swelling in the throat, with difficulty of breathing and swallowing. On the day of his admission to the hospital asphyxia had suddenly developed and an immediate tracheotomy was done by Dr. E. R. Gregg to relieve the breathing. A section was removed from the growth in the throat for microscopical examination and proved to be round cell sarcoma.

The case being considered non-operable, he was referred for X-Ray treatment. On examination I found a tumor on the right side of the neck extending from the clavicle upward to the middle of the cheek, of about five inches in diameter. The throat was almost occluded by the mass and swallowing even of liquids was almost impossible. He was given vigorous radiation every day for two weeks, then every alternate day for the same period; when a moderately severe burn occurred and treatment was discontinued for two weeks. However, at the end of the four weeks' treatment the external tumor had entirely disappeared, the mass in the throat was reduced to about one-fourth its original size, and he was able to swallow solid food without much difficulty. After the healing of the burn, he left the hospital and reported at my office for a continuance of the treatment, which was given semi-weekly for two months. At the end of this period there was no visible indication of the growth and he discontinued treatment. About one year later, I was informed that he had died suddenly, but I was unable to learn the cause of death.

Miss J., aged 48, admitted to the hospital for operation for abdominal tumor. Operated by Dr. E. R. Gregg. On opening the abdomen it was found that the parts were so massed and adherent that the case was non-operable. A section of the growth was removed for examination which proved to be

round cell sarcoma. After healing of the abdominal wound, she was referred to the X-Ray department for treatment. On examination a mass about the size of a small cocoanut was found in left side of abdomen. Treatments were given twice a week from October 6, 1909, to November 1, when on account of a severe attack of tonsilitis it was necessary to discontinue them. On November 26th, treatment was resumed and continued to January 1, 1910, when no trace of the tumor could be discovered by palpation. The patient however still complained of abdominal pain and the abdomen was again opened on January 28, 1910. Some intestinal adhesions were found, and separated, but no trace of the tumor was discoverable.

#### CONCLUSIONS.

The Rays most assuredly have a selective action upon the rapidly developing cells which contribute the essential part of most malignant neoplasms.

The beneficial effects of the X-Rays in cancer and sarcoma are the relief of pain by immediate action, the cure or control of the local lesion and a directly beneficial action upon the general health.

As radiation has proven curative in a certain proportion of cases without operation, it certainly appears that a conservative recognition of the importance of employing this form of treatment in connection with surgery is imperative, and there can be little doubt that it forms a valuable and effective means of dealing with non-operable cases and that it has a decided therapeutic action in recurrent growths, and is of value in preventing recurrences after operation.

With the clinical results verifying the theoretical therapeutic indications of radio-therapy, are we not neglecting the best interests of our patients if we do not give them the benefit of its application? We are not optimistic enough to assert that all malignant conditions can be permanently arrested or cured by X-Ray or any other form of treatment, but we do believe that the X-Ray has established for itself a field in therapeutics.

## DISCUSSION

DR. E. M. GRAMM: This matter is a subject of such interest and importance, particularly to gynecologists, and to surgeons, that I think we should dwell on it more and more every year; so that ultimately the surgeons and the general profession will recognize that in the X-ray, we have an exceedingly important agent. Dr. Pond's summary covers the ground most admirably, but I think, leaves us this thought, and that is if you want to use an agent, you must understand the physics that underlie its use. There is absolutely no sense in using an electrical modality, unless you know what you wish to accomplish, and how that electrical modality can accomplish the desired results. That is where the mistakes are made; that is where all the harm is in the use of either the X-ray or any other electrical modality. As Dr. Pond has told you, if you have an X-ray that falls short of the tumor, you produce no effect, or it is possible that some will filter through and stimulate the growth. If you have an X-ray that passes through the growth you have a ray which will stimulate the growth, but which does not cure it. If you have an X-ray which stops at the tumor, you destroy the growth. Now, it is just as rational to report a case of urethral stricture and say "I used a sound and the sound did not dilate the stricture." The question comes in, "What kind of a sound did you use?" "What size sound did you use?" And that is exactly what should come in in the use of the X-ray. "What current are you using to generate the ray?" "What tube are you using to throw out the ray?" "What protection are you giving the tissues that lie between the ray and the growth; in other words, between the outer surface of the body and the deep lying neoplasms?" Those are all things which can be estimated.

The X-ray has established its place; there is no question about that. Anyone who denies that the X-ray acts on neoplasms, malignant and otherwise, has not read the literature on the subject, nor any portion of it. The X-ray is a supplement to surgical procedures, as Dr. Pond's statistics show you, giving you a saving of lives of about 10 per cent.; and that 10 per cent. is a very large percentage, if it comes home to your own family, and one of the 10 per cent. is one of your own that is saved. We ought to have the same sort of feeling towards our patient, so that we ought to give the X-ray its appropriate place as a supplement to surgical procedures where those are possible, and to use it without surgical procedures, of course, in inoperable cases.

DR. HEIMBACH: I would just like to ask Dr. Pond how he



estimates the strength of the X-ray current in treating neoplasms.

DR. POND: There are on the market a number of meters for measuring X-ray currents; none of them at present successful. The dosage is very hard to know; it simply has to be a matter of judgment. I use a volt and ampere-meter and milliamper-meter, showing first the amount of current going into my coil and the amount of current going through the tube. Outside of that I use my own judgment, from the color of the tube and other surrounding conditions.

DR. W. B. BAYLEY: There is no doubt about the value of X-ray in malignant growths. In the superficial variety, as the writer of the paper remarked, we can approach the treatment of them with a great deal of confidence, a great deal of certainty as to the results. In the matter of deeper growths, there are many perplexing problems, some of which have already been discussed; the problem of the tube, the problem of the amount of the ray, the problem of the resistance of the patient, the problem of the type of the growth; all of these must enter into consideration and make the deeper growths more difficult to manage. The subcutaneous growths are difficult, by reason of the fact that we burn the superficial tissues in reaching them, no matter how well we gauge the activity of our tubes. Neoplasms of the breast I have treated with the X-ray; and I have felt it best judgment to always insist first on their surgical removal, following this with the preventive ray treatment. I have had three interesting cases of recurrence after breast operations that were seemingly cured by the ray.

One of the most interesting cases I have ever seen, which would come under the notation of a deeper growth, was a papilloma of the larynx in a young woman who had been voiceless for twelve years, during which time Dr. Shallcross used every means at his command to cure this papilloma. He operated on her repeatedly; he used all forms of local applications known to laryngologists, and finally, was about to remove the larynx, but as a preliminary, thought he would use the X-raying. This has been six years ago. I rayed her very vigorously, and the treatment was followed by a rapid and complete removal of the papilloma; so that her larynx has been for four years or more, as Dr. Shallcross says, absolutely normal; she has resumed her singing and altogether is apparently well satisfied, excepting for the scarring which resulted on the skin over the larynx; the unavoidable result of the active treatment.

DR. LANE: I think there is no doubt that the best results in breast cancer are obtained by as early removal as possible, followed by X-ray. I had one experience with a breast cancer

quite extensive, where the skin was extensively removed and it didn't cicatrize permanently. It would heal over and break down; it did that repeatedly. It was not a recurrence; it was one of those cases where possibly a skin grafting should have been done. I did a secondary operation on that case, to bring the skin edges together; but in spite of that it broke down again. The case was rayed very lightly. It healed very nicely, and has remained permanently healed, about six months I should say now.

I was very anxious to hear Dr. Pond say something about cancer of pelvic organs, cancer of the uterus, and if he has had any experience along that line, I wish he would tell us about it, because that has been a detriment to us in our work.

DR. POND: In regard to the pelvic organs, in my treatment, I have not had very successful results, as far as any influence on the growth is concerned. The one case that I cited went down into the pelvis to some extent. In these cases, however, even when the rays do not seem to have much effect on the growth itself, the general condition of the patient is improved. I have tried in such cases treating both through the vagina and through the abdomen; but seemingly, as I say, with rather poor success, as far as the growth is concerned.

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#### **SOME REMARKS ON THE KNEE JOINT, WITH SPECIAL REFERENCE TO INJURIES.**

BY H. M. GAY, M. D., PHILADELPHIA.

I WOULD like to call your attention for a few moments to a group of injuries, the treatment for which has changed somewhat since the majority of those present have graduated, viz., traumatism of the knee joint.

The knee, on account of its exposed position and its function is one of the common seats of serious injury, and aside from scientific interest in the anatomy, pathology and treatment, the subject ought to be of interest to the general practitioner as well as to the surgeon. It will be remembered that the knee has one of the most extensive and complicated synovial sacs of the body. Moreover, the shape of the knee joint, with its enormous articular surfaces, especially those of the femur, and its insignificant socket, make possible with apparently little external cause, the most extensive intra-articular injuries. In addition to those injuries associated with bone lesions, for example patellar frac-

tures, transverse or T shaped fractures of the condyles, epiphyseal separations, which of course are associated with laceration of the synovial membrane, we have that large class of injuries collectively spoken of as sprains, which range all the way from a slight stretching of the crucial ligament with a slight effusion of serum, up to a complete tearing of those fibrous structures going into the formation of the capsule of the joint, with extensive hemorrhages, etc. We also have open wounds of the joint, caused usually by direct violence, which may range from a small puncture, such as might be made by a nail, to extensive wounds such as might be found after crushing accidents, blasts, railroad injuries, etc.

The question arises at once, when such an injury is found, as to the advisability of surgical interference. Shall we wait for developments, such as suppuration in the case of open wounds, or ankylosis, either fibrous or bony, in the case of closed injuries, or shall we take the bull by the horns and institute active surgical measures. If so, in what cases is such interference justified, and to what extent? It would be impossible in a paper of this length, to more than touch the high spots in a subject so extensive. However, it seems that surgical practice in the past has been a trifle too conservative in these injuries. It has been the experience of the writer in his service in the West Philadelphia General Homœopathic Hospital, that the knee joint can just as successfully take care of the ordinary infections as can any other serous membrane. During my service there have been in the neighborhood of twenty open knee joints, none of which has suppurated, many of these injuries having been subject to contamination by street dirt before they entered the hospital. I believe the results have been due to the fact that we have always washed the joint out thoroughly in cases of open wounds, and further, and this is the most important factor, where the wounds are high up in the joint, we have invariably enlarged the incisions so that the final point of drainage has been at the most dependent portion of the synovial sac. I believe that the whole question of opening the knee joint hinges upon this one point more than any other, and I repeat that the position of the opening is the most important factor in this whole matter.

The first thought on looking at a perforating wound of the joint is to do as little as possible, probably washing it out superficially, inserting a gauze drain perhaps, and letting na-



ture take its course. I repeat again, that if that perforating wound is above the lowest point in the synovial sac we may expect suppuration, because when the virulent germs of suppuration commence operations we have immediately a coagulation of the synovial fluid. These infected flocculi will gravitate to the lowest point in the joint, there become attached in masses of plastic exudate and there continue their nefarious activity. No amount of washing will remove them. Having decided to drain at the lowest point, the question arises as to where the lowest point is situated, and here it is important to remember the position of the patient. In the standing position the most dependent portion would be below the patella, but in the recumbent position the lowest point is found on the outside of the joint, slightly below a line drawn transversely through the centre of the patella and may easily be found by passing a probe near this joint and so manipulating the instrument that the position of the point may be found on the skin. When we have done this we have to do one of two things: we may extend the original opening to this point, clean out the joint, sew up the opening, but leaving the most dependent portion of the wound open; or we may make a counter opening. Personally I prefer the former procedure, because the larger opening gives a better opportunity for examination and cleansing and when the sutures have been placed we have left one opening instead of two. In suturing we have always sutured the wound in layers, first the synovial membrane, next the fibrous tissue (joint capsule), then the skin and superficial fascia. In cases where the probability of infection has been great, for example, open street wounds, we have used rather large capillary drains. On the other hand, where the injury has been made with a fairly clean article, or in cases where we have opened the joint ourselves, a single strip of iodoform gauze, one inch wide, has been sufficient. The irritation in the joint causes an excess of synovial fluid to be thrown out, which works its way out through the opening.

Returning to closed wounds, what are the indications for opening the joint? First, fractures of the patella where there is separation of the fragments, especially transverse fractures. In these cases the joint should be opened, cleansed, and the fragments fastened together with preferably forty day chromatized gut, passed through the tendinous covering of the bone. When made under aseptic precautions these wounds will not

need drainage. The results should be perfect in ninety-nine per cent. of the cases.

In serious sprains, where abnormal lateral mobility indicates extensive laceration of the ligaments, the joint should be opened. We had one case where the entire fibrous capsule from the edge of the patella down to the edge of the popliteal space was torn through, with ragged radiating tears of the synovial membrane which required, if my memory serves me, about forty stitches of plain catgut in the synovial membrane alone, with enormous hemorrhage into the joint, which made an uninterrupted and perfect recovery after having been operated. With the ordinary expectant treatment, these cases invariably result in permanent disability, with weakness and fibrous ankylosis.

In fractures of the condyles, surgical interference is not indicated unless there be enormous effusion of serum or undoubted evidence of blood into the joint. Joint juncture is advocated in these cases, but I have had no experience with it. Personally I have no faith in it. Either the joint should be opened properly or not at all.

Lastly, we have those cases of epiphyseal separation in children, with rotation and dislocation of the epiphysis, which from the very nature of the case must always require surgical interference. I am aware that extension and counter extension is advocated for the reduction of the deformity in this injury. But if for one moment we will consider the anatomy of the knee joint, the relationship of the patellar ligament to the tibia, the points of attachment of the gastrocnemius, it must be seen that such a procedure is worse than nothing. The only hope of reduction without opening the joint would be in manipulation, and on account of the epiphysis being hidden under the quadriceps extensor femoris, manipulation is extremely difficult. Scudder, of Boston, recommends opening the joint at the side of the patella and coaxing the epiphysis into position with the help of two especially constructed hooks, making upward traction on the upper fragment and downward traction on the lower fragment. But when we consider the fact that one of the hooks is across the face of the shaft of the bone, at the exact point where we wish the approximation to take place and a like condition is true of the lower fragment, and also that a very considerable traction must be made all the time the operation is going on, and that there is no way by which the

traction can be kept up except by the hooks, we must see that the hooks are in the way of the very manipulation we are trying to make. In other words, after we have pulled the bones into position, the problem of removing the hooks from between the ends of the fragments must present an unsurmountable difficulty.

I present for your consideration two radiographic plates, showing such an injury successfully reduced with perfect functional and anatomical recovery, obtained by opening the joint transversely, sawing through the patella, flexing the joint and manipulating the dislocated epiphysis into place with the fingers. The stubbornness with which this deformity resisted manipulation even under these most favorable circumstances will be made plain when I state that it was necessary to pass a heavy instrument back of the upper fragment, which was grasped firmly with both hands, the thumbs being used to rotate the epiphysis into place before the deformity could be reduced. As far as I know the procedure is a new one, but to my mind is justified and reasonable when we consider the disability such an unreduced deformity must cause. We expected that there would be some fibrous ankyolous to be broken up, but the boy left the hospital with a cast on, promising to return. But it was necessary to hunt him up in order to take the last radiograph, which was taken two days ago, some eighteen months after his leaving the hospital.

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### THE BOY.

J. C. CALHOUN, M. D., PITTSBURGH.

In going over my work for the past year to find a subject for this paper, I find that the little boy comes to the front.

At birth he is more or less neglected by the most of us, so it seems to me. His lot is that of phimosis with adhesions in a vast majority of instances. I hear some of you say, but nature takes care of that for him. Maybe so, but there are quite a few left that need the attention of the physician or surgeon.

In going back over the year's work I find somewhere near a dozen little boys ranging in age from six months to three years that have called for attention. I will give the history of a few by the way of illustration.



Case I. J. B. aged 9 months, nervous, so mother says. Does not sleep well, peevish, does not thrive as he should. Appetite and bowels normal.

Examination showed foreskin adherent around meatus. Adhesions broken up, foreskin dilated and put back, smegma removed, glans oiled. Mother instructed as to the hygienic care. Marked improvement in all conditions.

Case II. McB. aged 6 weeks. Restless, crying much, liked to lie on his stomach or have some one rub his stomach. Examined him during one of his spells. Found penis erect. Phimosis existed. Dilated, broke up adhesion that existed at the corona. Removed accumulated smegma. Cleaned and oiled. Instructed mother as to care. Reports two months later a different child.

Case III. C. W., aged 2 years. Child very nervous sleeper, irritable, poorly nourished. Inclined to handle self.

Examination showed foreskin with a very small opening which at the late date could not be dilated sufficiently to clear glans. So did a circumcision. One month later mother reports a different child. Four months later that he gained ten pounds.

Case IV. A doctor friend of mine asked me to anæsthetize a boy so that he could do a circumcision. Under anæsthesia the adhesions were broken up and it was found that there was no need for the operation, as the adhesions were the sole cause of his trouble.

Case V. G. S., aged 5 years. Brought to me suffering from a swollen and sensitive foreskin, that was discharging a heavy pus. By bathing and a little care inflammation reduced. Later under chloroform circumcision intended but found that when adhesions were broken up that circumcision was not needed. Instructed parents as to care. That was four years ago and he has had no return of his trouble.

You no doubt could add many more such cases from your experience.

Now what can we do to help along the parent so that the child escapes this trouble? Recently it has been my custom on 7 to 10 days, when necessary, to dilate the foreskin with an artery clip, break up the adhesions that were present, remove the smegma and oil. Instruct nurse to push back well each morning, cleanse thoroughly, oil and bring forward again, as soon as all lacerated surfaces are healed, to discontinue oil.

I have been much surprised recently to find how many mothers really do not know how to care for the boys, while on the other hand, the little girl has the perfect care.

If we as physicians gave a little more time to explain and show the nurse or mother how to care for the boy, I believe that a great deal of his trouble could be prevented.

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## BUREAU OF SANITARY SCIENCE

G. J. BERLINGHOF, M. D., Chairman

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### OBSERVATIONS ON THE SPECIAL SENSES.

I. D. METZGER, M. D., TYRONE.

THE human body is an extraordinary piece of machinery. Every part of the anatomy is so constructed, so well poised, so skillfully arranged, and so marvelously adjusted as to place it at the zenith of all creation. Even the Creator Himself looked upon this last product of His handiwork and said it was very good.

But, however perfect may be the component parts of machinery, if it have not the power to perform its peculiar work it is useless. In its functioning power, this human engine stands pre-eminent. It is not only conscious of its own status but it is exquisitely sensitive to every phenomenon of its environment. A flash of light, a piercing sound, a fragrant odor, a gentle touch, and the bodily organism is quickened to the consciousness of some alteration within itself or its surroundings. All the properties of matter, size, weight, temperature, taste, position, etc., can in some way be recognized by this human organism and, by its dominant master, the mind, be elaborated and co-ordinated to their proper relations. Sensitiveness is a property of all animals, and probably of not a few plants. Some animals, however, are so low in the scale of organization as to be oblivious to special sensory impressions, but every part of their body seems alike fitted to recognize variations in its surroundings. As soon as we pass to the higher grades of animal life, we find certain parts, or organs of sense, whose duty is to keep the body in touch with its surroundings; and a nervous system which receives impressions and ensures the co-opera-

tion of all the individual elements of the body one with another.

In order, therefore, that the proper correlation may be sustained between ourselves and our environment, we are provided with a central nervous system, or sensorium, with nerve fibers passing to certain parts of the body ending in special terminals to respond to some peculiar variety of impression. These form the so-called special senses,—touch, taste, smell, sight and hearing.

It would be an unwarranted presumption for the writer to attempt to present any didactic study of the *modus operandi* of these specialized organs. A few matter-of-fact observations, however, may not be amiss in enhancing our appreciation and care of these marvelous hand-maidens to human development. The evolution of the mind is dependent upon data furnished by the senses. Take away the functionary power of one of these and you limit the possibilities of the person's mentality to the extent in which the remaining ones are unable to compensate for the same. Each of the five specialized organs adds its quota to produce the complete man. Scarcely two individuals harmonize in the manner of their development and very few present a harmonious development of all the senses. Peculiarly keen development of any one special sense leads to the production of a genius in a certain line. If this occurs at the expense of the others, we are apt to have as a resultant a meteoric weakling. The aim of human culture during the nascent period of life should be to evolve a symmetrical adult by giving opportunity for the exercise and growth of all the special organs of sense, and, through them, of all the faculties of the mind. One of the weak points in many school curricula is their failure to take cognizance of the need of all the senses. Some are left for training to the incidents of the home and society. If these be lacking in opportunity, development is neglected. One of the chief sufferers of this neglect is the tactile sensation. Until the advent of manual training, the city child remained practically oblivious of the benefits to be derived through skillful training of this sense; and the country child was warped into the peculiar trade of his parent without concern as to adaptibility. The varied advantages of country life, however, make possible a general training of all the senses, hence we here find the best example of the "all-around" man.

Analogous to and perhaps identical with the Pacinian corpuscles of touch are the organs by which we appreciate tem-



perature. Only the skin can perceive heat and cold. To irritate the nerve itself gives a sensation of pain, but not of variations in temperature.

The skin, then becomes the regulator of bodily heat. Have you ever observed the modern ingenious mechanism for the automatic regulation of the temperature of rooms in large buildings? A magnetic instrument it is, so delicately poised as to respond to variations of temperature of even two degrees. This thermostat, being connected with the source of heat, adjusts the in-take of either heat or cold so as to maintain a constant temperature. Nature long ago provided even more dexterously by providing the skin as a thermostat to the bodily temperature. The balance between heat-production by oxidation and heat-dispersion through evaporation is admirably maintained by the impetus transmitted to the vaso-vasorum nerves by the skin under the required conditions. Should there be any interference with this thermostatic action of the skin, the whole organism becomes susceptible to many lurking maladies. The so-called "colds" which appear to form the basis of various more serious diseases, spring from the inability of the skin to maintain this temperature equilibrium. The unbalance of the climaxis, producing frequent hot flashes, may do much in making this the critical period in a woman's life.

If the thermostat in the building should be neglected by non-use or misuse, it would soon become unreliable. So the skin needs guarded care to be most efficient. The muscles of the blood vessels must learn gymnastics, i. e., they must be taught to meet sudden effects of heat and cold by a corresponding contraction or dilatation. Proper clothing, bathing, exercise, ventilation, etc., need to be taught to patients every hour of the day by the physician as well as by the public school teacher. Water is a most effective stimulus to the cutaneous blood vessels. It is doubtful if any physician passes a day without seeing some patient who could profitably renew his acquaintance with this omnipresent cure-all of nature.

Much stress is laid during the last few years upon the phenomenon of blood-pressure and its effect upon the vitality of the patient. It seems to me an investigation of the peripheral circulation as effected by the peculiar condition of the thermostatic regulation by the skin, might aid us in solving some of these circulatory mysteries. Dr. Finley Cook, of New York, and others have already demonstrated that the blood pressure

may be materially reduced by inducing peripheral hyperemia by means of the X-ray flashes.

The delicate mucous membrane of the nose, throat and accessory sinuses is apt to be the first to react to circulatory unbalance. The vasovasorum nerves in these areas may respond to stimuli that those of the skin do not, resulting in the hyperemia and inflammation of "colds." Whether these be local or not, if oft repeated, their ultimate effects must needs be systemic.

The special senses of taste and smell, though regarded as being somewhat secondary, are capable of producing exquisite pleasure and of affording invaluable protection to the system when accurately developed and properly functioning. The development of these seems scarcely to have been thought of in systematic education.

As to structure and function, the eye represents perhaps the acme in the human mechanism. And yet, this most ingenious organ is apt to show serious defects as an organ of vision. Sight is purely relative. Every one else's vision is apt to be judged by our own perceptive power. Snellen's chart method gives us an approximate idea of the visual power of the eye, but fails to reveal some of the most injurious forms of eye strain. Frequently persons pride themselves on their remarkable sight because of their ability to see farther than their associates. Even the physician may fail to recognize in such a person the possibilities of a dangerous form of hyperopia or hyperopic astigmatism. The opinion still seems to prevail that, unless a child's face is buried in his book from excessive myopia there need be no haste in ascertaining the need of glasses. If the family physician should be alert in urging the careful investigation of every patient's eyes, the many cases of astigmatism would be corrected and their consequent possible myopia be avoided. Every physician should have a set of test-types and hereby ascertain early in life the approximate condition of every patient's eyes. Let us not be so stupid as to permit the school authorities through systematic inspection to anticipate us in our own sphere of work. Nearsightedness, it should be generally known, is an acquired condition, frequently resulting from the child's effort to overcome his far-sighted astigmatism which is a congenital defect. The process of elongation of the eye, causing myopia, may follow the attempt to overcome astigmatism or hyperopia by reading in a poor light, improperly placed light, bad print, or when the eyes are weakened from systemic

debility. In debilitating diseases the tunics of the eye may be easily stretched and the integrity of the eye thereby be permanently impaired.

As to diseases of the eye, let us never forget that some of the graver ones develop insidiously and can only be detected by a discerning examination. Any unfamiliar alteration in ocular appearance or in vision should prompt the general practitioner to hastily refer the case to a skilled oculist and thus relieve himself of any unwarranted responsibility.

The sense of hearing is peculiarly the neglected special sense. True, it is better to do nothing than do wrongly in treating any organ of the body. A protest against the unguarded syringing through a perforated membrana tympani for suppurative otitis media, should be strongly presented. Not a few mastoid abscesses and chronic attic suppurations result from the general advice to "syringe the ear." Wiping the external meatus with pledgets of cotton, both dry and wet, will be just as effective and much less dangerous. The much used peroxide of hydrogen should rarely be prescribed for general use in the ear. It macerates the delicate tissues of the middle ear as well as those of the canal making them more vulnerable to graver infections.

The treatment par excellence for the ear is prophylaxis. This must have its initiative with the general practitioner who stands on picket duty as guard against the onset of any possible malady. The majority of diseases affecting hearing develop in the middle ear and have their origin in the throat. Nasal respiration is most important so as to secure warm, moist and clean air into the lungs; but just as important, to secure the proper circulation through the brain. When the nasal passages are free every inspiration empties the ethmoid veins and, through them, the longitudinal sinus and cavernous plexus. If the nasal passages are obstructed this mechanism is impeded, venous hyperemia is apt to occur, resulting in dull, drowsy headaches, and when persistent, in the aprosexia of the confirmed mouth-breather. The obstructed nose causes a hypermic nidus in the nasopharynx for lymphoidal growths. The result is a chronic hyperemia of the mucous membrane of the pharynx, Eustachian tubes and middle ear, putting them into excellent condition to develop any infective bacteria. The persistent effort to clear the nose by blowing soon supplies the infection and the vicious course is in process. By the way, the proper method of nose-blowing needs to be taught to many of



our patients. The tendency is to hold tightly shut both nostrils while blowing, leaving the Eustachian tube the only avenue for escape. This hyperemia of the tubes narrows their caliber so that the process of swallowing fails to aerate the middle ear. The tissues absorb the oxygen from the air existing in this cavity producing a partial vacuum. The unequaled air pressure from the outside causes a retraction of the drumhead, formation of adhesions by the catarrhal process and consequent catarrhal deafness,—the chief aural defect to be dreaded. Relief from impeded nasal respiration, if secured early and conscientiously, will soon greatly reduce the percentage of deafness.

Ignorance and superstition ever remain as the chief barriers to individual as well as public health. A wave of enlightenment concerning the care of the special senses along with that of general health is awaking the laity to their needs. As physicians, let us not be fearful of this publicity but welcome it as a great boon to humanity and as a valuable adjuvant in the administration of our healing art.

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SYPHILIS IN THE LOWER ANIMALS.—Hoffmann (*Munchener medizinische Wochenschrift*, March 28, 1911) sums up our results as to experimental syphilis as follows: If we inoculate the lower apes subcutaneously, we get at times insignificant evidences of secondary syphilis. But if we inoculate the same animals in the scrotum, we obtain after three months very characteristic generalized syphilis—papulous, pustulous, etc. Syphilis is found to be a local malady until the spirochetes enter the blood, but this occurs at so early a period that the malady may be termed constitutional from the start. It is an error to believe that rabbits, etc., are more susceptible to syphilis than the higher animals. The peculiar susceptibility of small laboratory animals to corneal and testicular inoculation is misleading in this direction. Nevertheless, corneal studies of inoculation in rabbits, etc., are full of interest. Double inoculation of the anterior chamber "takes" in nearly all cases. In about one-half the cases inoculation of one eye is followed after about two months by syphilis of the opposite eye. The corneal lesion, nominally a keratitis, is actually a syphiloma, but one which may resemble structurally a tuberculous neoplasm. However it seems able to imitate almost any type of corneal disease. Thereby it differs wholly from the syphilitic keratitis of human beings, which is not only never a primary lesion, but also falls under a few definite types. The primary inoculated syphiloma of the cornea in animals remain a lesion *sui generis* and as such must be considered in pathology, with no reference to any other lesion whatever.—*Medical Record*, April 22, 1911.

## EDITORIAL

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### TO THE MEMBERS OF THE HOMOEOPATHIC MEDICAL SOCIETY OF THE STATE OF PENNSYLVANIA.

ORGANIZATION is the keynote in the success of all large enterprises. In making a study of various lines of business we find that each one is represented by a strong, active organization, made up of the heads of many individual business interests. We find these men grouped together and thoroughly organized to promote the best interests of their special business, to better trade, to create demand and to propose or oppose laws according as these further or are detrimental to their well being. Competitors these men may be in their line of business, but they work shoulder to shoulder in their organizations for the common good, each individual realizing that he will profit by improved conditions, by the demand created for his line. These shrewd men of business look upon their organizations as of vital importance; they are keen in their attendance upon the meetings, active workers in these organizations and they look upon time so spent as a part of their business and consider such time well spent.

The physician who is alive to his own best interests, is the one who takes an active part in the organizations of his profession. He realizes that by joining with his colleagues, by co-operating with them for the general good of the profession, he is not only working to increase respect for his profession but that he is also materially advancing his own professional standing, his own interests. In our great State Society there have been many such workers, many good men who have worked unceasingly and untiringly to advance the interests of our school of medicine in this State. These men have done much to preserve our professional standing, they have done much to keep our good ship from hidden rocks. Others of our good men have not as yet awakened to the necessity for activity on their parts. Apparently secure in their good practices, they as yet cannot see the necessity for devoting time to their state society, nor have they realized that were it not for the

active members, their professional standing would have materially suffered through unopposed vicious legislation.

The improved conditions in our profession have been due largely to organized work in our societies. If so much good has resulted from the amount of energy thus far expended, to how much greater an extent our interests would be furthered, were every one of us keenly alive to our duties, wide awake to our best interests and ever ready to join with our colleagues in organized movements for the good of homœopathy.

The State Society has done a great work in Pennsylvania, but it can be made a far greater factor, a far greater power than it has been in placing homœopathy upon a stronger basis than it now occupies; it can do much more to create demand for homœopathic treatment. Will you not help to make this new year one of great progress? Every one of you is an important part of our Society; every one of you can do much to help along our cause. If you have been an active worker, then become more active; if you have been inactive or apathetic, will you not shake off your apathy, get into the harness, lend your advice, your encouragement, and your good work and so give to our school an impetus which said help will give?

In every issue of our "official organ," the HAHNEMANNIAN MONTHLY, will appear news of our Society, as well as that of the various county and other societies. Read these and keep in touch with society matters. Help us to increase these news items by sending in anything of importance and let us know what is going on in your section. Make your plans to attend our next meeting in September and be assured that you will return home well pleased, more interested and glad that you are a member of the State Society.

GILBERT J. PALEN, *President.*

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#### THE PUBLIC AND THE MEDICAL PROFESSION.

IN a recent address before the New York Academy of Medicine, Dr. James Ewing, Professor of Pathology at the Cornell University, School of Medicine, took as his subject the attitude of the public toward the medical profession. Dr. Ewing stated that "There is no denying the fact that the public holds quite a different conception of medicine from that of the physician, and that there is a growing distrust in medical practice and an in-



creasing dissatisfaction with its results." He then proceeds with a rather elaborate defence of the medical profession, and attributes the criticisms that have been made largely to "ignorance, superstition and an inherent defect of the human mind which opposes correct thinking along medical lines."

Dr. Ewing then proceeds with specific charges against the public and attributed their attitude toward the profession to the following factors:

First.—As a result of superstition and of the influence of the church the modern mind is unfitted to grasp the intricacies of biological processes and, therefore, does not understand medicine.

Second.—That the public misconception of medicine is partially due to the sensationalism and absurdities of the daily press.

Third.—That the public does not appreciate the advantage of specialization and believes that the opinion of a Robert Koch is only in a vague way a little better than that of the family physician.

Fourth.—The public has never given adequate material support to institutions for medical research, and, in fact seems to have a meagre appreciation of the value of such research.

After a careful consideration of Dr. Ewing's address, we do not feel that his defence of the profession can be considered a very convincing one. It partakes more of the nature of a scolding than of a rational appeal calculated to convince those who disagree with him. There is, no doubt, a large element of truth in many of the ideas expressed by him, but at the same time, we cannot close our eyes to the fact that the loss of prestige on the part of the medical profession, is not alone the result of ignorance and superstition on the part of the public. The profession itself is, in a large measure, to blame, and it behooves us as physicians to give this matter serious consideration and to ascertain wherein we have fallen short of the demands that are made upon us.

To take up Dr. Ewing's reasons *seriatim*, we note that his first charge is that "as the result of superstition and of the influence of the church the modern mind is not able to grasp the intricacies of biological processes and does not understand medicine." We confess that we are somewhat surprised at the nature of this statement. While every physician recognizes the prevalence of a spirit of mysticism and superstition, even among

the more intelligent of the laity, yet, surely no one would attempt to prove that superstition is more prevalent to-day than it was in the past centuries, and certainly the attitude of the church, as a whole, has been to support rather than to antagonize the medical profession. As to the modern mind being unable to grasp the intricacies of biological processes, and is therefore not able to understand medicine, we are impelled to believe that if such a condition is prohibitive of successful medical practice, it is doubtful whether medicine will ever prove of value to the vast majority of the human race. If medicine, like ethical culture, is merely for the scholarly and the philosophical, its field will certainly prove a very limited one and the great mass of humanity must turn somewhere else for relief from disease. As a matter of fact, we find that men learned in the intricacies of modern science are among the most difficult patients we have to deal with, and the practical help that physicians of to-day and of former days have been able to extend to the poor and the ignorant, conclusively demonstrates that however desirable theoretically, such superior mental training is not necessary to the successful application of the healing art.

Sensationalism on the part of the daily press is another factor that has disturbed the confidence of the public in the profession according to Dr. Ewing. That such sensationalism exists and that many absurdities are published by the press is unquestionably true, but, as a whole, we do not believe that the attitude of the press is harmful to the profession. The average paper is more inclined to speak favorably than otherwise of physicians and of the progress of medical science. Indeed if we could credit all of the statements of the daily press regarding the advances made in medicine and surgery, we would have good reason to feel proud of ourselves.

The statement that the public does not appreciate the value of specialization in medicine is incorrect. If Dr. Ewing were engaged in the active practice of medicine, he would appreciate the fallacy of his position in this matter. In fact it is a matter of complaint among general medical practitioners that as soon as a patient has more than a trivial ailment he wants to go to a specialist. Not only is this true, but he does so with the full knowledge of the fact that he will ordinarily be expected to pay a fee much larger than that charged by the general practitioner. The rapid development of specialties, and the proportionately larger fees received by specialists, demonstrates conclusively to

our mind that this statement is based upon an entire misunderstanding of conditions as they exist to-day.

Dr. Ewing states that the public has not provided adequate material support for medical research. To an extent this is true, and yet it is off-set by two facts: (1) that a number of wealthy philanthropists have, during recent years provided quite liberally for such research work, and (2) without having the exact figures, we are inclined to believe that medical research has been provided for quite as liberally, relatively speaking, as other departments of scientific investigation.

The view urged by Dr. Ewing that the government should largely provide for such work is unquestionably correct, and we cannot look for the contribution of money by wealthy philanthropists, who are induced to make a gift now and then because of interest in some particular disease, to support this work properly.

The failure of Dr. Ewing to get at the real reason for public dissatisfaction with the results of medical practice is, to our mind, very evident. Fault finding and scolding can never restore the medical profession to the position it once held. Ignorance, superstition, sensationalism, lack of appreciation and of financial support have always existed and probably always will, and while they present obstacles to success, if the profession fully measures up to its duty, those obstacles can never prevent the successful attainment of its legitimate aims. In our opinion, the present position in which the profession finds itself, is due to its failure to realize exactly what its mission is. And yet, the function of the doctor can be comprehensively and briefly stated in a very few words, viz., *to cure and prevent disease*. The public is very little concerned with the great problems of biology, bacteriology, pathology and all the other sciences that are of vital interest to medical men. Its only demand of the doctor is, that he "deliver the goods." The object of a sick man in coming to the physician is not to obtain long, detailed statements regarding the pathology, etiology, etc., of his illness, but to be relieved or cured of the symptoms of the disease that afflicts him. We cannot emphasize this fact too strongly because it is the one fact that many medical men have largely lost sight of; and it is this more than all other things combined, that has caused the public to lose its confidence in the profession.

It seems strange how difficult a matter it is for the scientific investigator in medical research to realize how useless his work



appears to an individual suffering from disease, unless that work enables the investigator to alleviate his suffering or to restore him to health. The average individual is not at all particular about being cured in the orthodox way by a regular physician. He is just as well satisfied to be cured in an unorthodox way by an irregular physician. The vital point with him is the fact of getting cured, and in his "ignorance and superstition" he invariably seeks the aid of those who, in his opinion, can bring about this consummation so devoutly wished for.

Dr. Ewing himself expresses the opinion that the public patronage of the numerous cults is due to failure of regular physicians to deal successfully with a host of minor ailments. To the "ignorant public" the question naturally arises: "How can physicians who are unable to deal successfully with minor ailments, hope to cure serious diseases?" Herein lies the pith of the whole matter, and the sooner physicians learn to deal successfully with both minor and major ailments, the sooner will they regain the confidence and support of the public.

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#### IMPORTANT NOTICE TO STATE SOCIETY.

The treasurer of the Homeopathic Medical Society of the State of Pennsylvania has notified the Board of Trustees that a number of members have not paid their dues for the year 1911. The treasurer has been instructed to advise the publishers of the *HAHNEMANNIAN MONTHLY* not to forward the Journal during the year 1912, to members who are in arrears for 1911 dues, until such dues are paid to the treasurer.

This action on the part of the Board of Trustees was necessary because of the fact that under the contract between the State Society and the *HAHNEMANNIAN MONTHLY*, the State Society is required to pay two dollars for each member whose name is sent to the publishers of the "*HAHNEMANNIAN*" and certified to as being in good standing in the State Society and entitled to receive the transactions published in the journal.

All members who are in arrears in their dues are urged to forward the amount due at once to Dr. Ella D. Goff, Library Place, Pittsburg, Pa., in order that their names may be put on the official list of those entitled to receive the journal.

## GLEANINGS

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OINTMENTS, WITH SPECIAL REFERENCE TO THE SUBSTANCES USED AS BASES.—Wild (*British Medical Journal*) says that a number of experiments have been made to determine the relative protective and penetrative powers of the various bases, and also the extent to which certain active drugs were absorbed by the skin when applied to it in the various combinations. The experiments were made by rubbing a carefully weighed quantity (usually 10 grains) of the ointment or base into a definite area of skin (usually 20 square inches) for a fixed time. The ointment was then scraped off the rubbing finger and the surface of the skin by a dulled Gillette safety razor blade fixed in a convenient handle, and again weighed. To avoid the necessity of wiping the instrument the scraper is weighed with the ointment both before and after rubbing. With a little practice consistent results may be obtained. The loss of weight represents the amount of ointment absorbed, together with the amount lost in manipulation; as the latter is fairly constant in dealing with preparations of a similar consistency the results afforded a relative indication of the respective amounts absorbed. There may, of course, be a possible slight gain from secretion and epidermis removed from the skin by scraping, but if the skin is dried before the rubbing, experiment has shown that this factor may be neglected, as it is the same for each application and does not affect the relative results.

These experiments are still in progress, but sufficient results have been obtained to confirm the generally accepted views as to the relative penetrative powers of the usual bases.

Soft paraffin and paraffin ointment appear to be hardly absorbed at all, but remain on the skin as a protective layer for a considerable period. Lard and olive oil are absorbed to a considerable extent, about 15 per cent., after two minutes' rubbing. Hydrous wool-fat, 20 per cent., provided the proper amount of water is present; old samples partially dried are less absorbed. Owing to its powerful adhesive properties no reliable result was obtained from anhydrous wool-fat.

The greatest loss of weight occurred from a mixture of equal parts of glycerin of starch and wool-fat, which is a useful base when a comparatively non-greasy emollient is required.—*Charlotte Med. Jour.*

ALCOHOL FOR HAND DISINFECTION.—Schumburg, in the *Deutsche Medizinische Wochenschrift*, says that washing the hands with strong alcohol is a most effective means of removing all infection and rendering any bacteria innocuous. He says that 200 c.cm. of alcohol applied with a pledge of cotton-wool are sufficient to disinfect the hands to the extent of 99 per cent. or more of all bacteria present. Ordinary methylated spirit is quite effective. From experiments in the medical department of the Prussian

Ministry of War it appears that washing with soap and water combined with even prolonged scrubbing with a brush does not remove the microbes, the soap softening the skin and making the bacteria more adherent. Alcohol, on the other hand, by hardening the skin, causes the bacteria to become rapidly detached. To secure proper disinfection with alcohol the preliminary use of soap and water must be dispensed with, the reasons given being that the residual moisture, even after drying, dilutes the alcohol, and further that the softening of the skin by water causes it to contract too strongly when the alcohol is applied, and by rendering it rough and scaly encourages the transference of bacteria from the surgeon's hands to the wound. Inasmuch, however, as the wearing of gloves for operations has been now so generally adopted, disinfection of the hands has not the same importance that it once possessed for the success of aseptic surgery.

THE PRACTICAL METHODS FOR THE PREVENTION OF GONORRHEAL INFECTION.—Guiard (*Medecin Practicien*) says the prevention of gonorrheal infection should consist, in the first place, of forcible urination after compressing the meatus in order to artificially raise the pressure of the fluid, as it passes through the urethra. This measure, however, is not sufficient in itself, nor are the simple or antiseptic washes which are recommended, because they do not reach far enough into the urethra. The best methods are those which prevent the entrance of the gonococcus into the urethra (condoms), although even these do not offer absolute security. The use of lubricant ointments does not protect against the invasion of the gonococcus. Excellent methods of protection consist in the introduction of various antiseptics into the canal, such as nitrate of silver or protargol, but the strength of these solutions, as usually employed, is too irritant and the small quantity used necessitates a restriction of their activity to a small portion of the canal. In the author's opinion, the best preventive method consists in the injection of solutions of potassium permanganate, through the entire anterior urethra. The strength of these solutions should vary from one part in ten thousand to one part in five thousand. If thoroughly carried out, these injections constitute the safest and best preventive measures against gonorrheal infection. The preventive irrigation should be carried out within two or three hours after exposure. The necessary material for these injections is as follows: (1) A syringe graduated in cc. holding 25 cc. which should be kept in a test-tube filled with potassium permanganate solution. (2) A graduate holding 250 cc.; (3) a stock solution of potassium permanganate, one part in a thousand; several litres of sterile water, and a small gas stove or alcohol stove. The solution should be freshly prepared, with sterile water. The patient should be instructed how to make up the solution and how to inject it. The anterior urethra should be filled with the solution, which should be held therein for a few seconds. This should be repeated five or six times. If the injection is delayed for 12 or 15 hours after exposure, it should be repeated several times in the same manner at intervals of 10 or 12 hours.—*Charlotte Med. Jour.*

INJURIES OF THE ABDOMEN.—Richard v. Hippel (*Zeit. fur Versich.*) continues his consideration of this subject. He says that the stereotyped



description of dullness in the right flank as due to injuries of the liver and of that in the left flank as due to injuries of the spleen is not at all applicable to all cases. The dullness due to the blood effusion may be found anywhere, according to the various positions of the body assumed after the injury. Liver dullness at first is unchanged; soon after injury it may be increased because of the collection of blood near the liver, later it may diminish because of the developing meteorism or dislocation of the liver itself. With the development of peritonitis liver dullness progressively diminishes. The same signs may accompany injuries of the spleen. Fortunately, however, it is not important to decide which organ is the seat of injury and hemorrhage, for an abdominal section is indicated in any case. Surgeons, too, should not be so inclined to wait until the symptoms of shock have entirely subsided. Shock will usually disappear with the cessation of hemorrhage, and frequently this stilling of hemorrhage can only follow an operation.

Injuries of the stomach usually give signs of free air in the peritoneal cavity and a metallic percussion note or simple hyperresonance, changing in site with change in position of the patient, should be diligently sought for. Circumscribed dullness, if found, should be immediately marked out on the abdominal wall; it may be due to an exudate and the increase in size may clinch the diagnosis. Larger area of dullness usually mean perforation of the small intestine with the infection of the peritoneal cavity, by a considerable quantity of fecal material. Of course, none of these signs may be present in any given case. If, a short time after injury, the pulse is quickened, tenderness and reflex spasm of the abdominal muscles have appeared, there is spontaneous pain on deep inspiration, and the patient has become somewhat restless, injury of the intestines must be suspected, if there are no signs of internal hemorrhage.

Ruptures of the urinary bladder are usually accompanied by fractures of the pelvis. Direct injury may rupture an overfilled bladder and this usually happens in drunkards. Vesical tenesmus, ineffectual or resulting only in the appearance of a few drops of blood at the meatus, is a very frequent symptom. Catheterization usually confirms the diagnosis; the difficulty is in deciding whether extraperitoneal or intraperitoneal rupture has taken place. V. Hippel closes his lengthy paper with the urgent advice to send all patients in whom an intro-abdominal injury is suspected to a hospital, so that immediate operation may be performed if the suspicions are confirmed by further study of the symptoms.—*Charlotte Med. Jour.*

**HYGIENIC AND DIETETIC TREATMENT OF HYPERTENSION.**—By Arthur R. Elliott, M. D. (*Therapeutic Gazette*). There are a few cardinal rules in the dietetics of high blood pressure which are generally accepted and which with individual variations are applicable to all cases:

1. Reduction in the total quantity of food. The extent to which this is carried must of course be governed somewhat by the physical type, habits and activities of the individual. Digestive plethora is, however, the rule with these patients. They either eat too much absolutely or too much relatively to their digestive powers. In either case quantitative reduction is advisable.

2. Limitation of protein. In arranging the diet for all hypertension

cases of whatsoever origin the amount of protein food should be restricted within certain limits. The average adult does not need for physiologic purposes more than 90 grammes of protein per day. In every case of hypertension the protein should be kept within this amount. In renal cases of high blood pressure the amount ingested must be limited to what the kidneys can take care of. In advanced chronic nephritis it may be necessary to reduce the protein ration to as low as 50 or 60 grammes. A somewhat more liberal policy may be followed in cases that are primarily vascular rather than renal in origin. This is true as well of those patients who cannot digest fats and carbohydrates well. As the extractives of meat have a certain influence in raising blood pressure, boiled meats may be permitted in somewhat greater quantity than roasted. The great bulk of the diet should be made up of cereals, vegetables, fruits, and farinacea, but even these should be regulated on a physiologic basis and not haphazard. Coffee should be excluded, and alcohol permitted only with the strictest moderation.

3. Milk diet. An exclusive milk diet is not appropriate for routine use in arterial hypertension, even when the case is one of chronic nephritis. Leaving out the question important individual considerations, it is poorly adapted to care for the nutritive needs of the patient. In order to supply the requisite number of calories it is necessary to give at least three quarts of milk daily. This quantity of milk represents 120 grammes of protein, which is at least one-third more than should be allowed in the average case. If milk in any form is added to a diet already including a protein ration due allowance must be made for it, otherwise excess of nitrogen will be given. Notwithstanding very valid objections to the milk diet as a routine measure, we find it at times of decided value. When the pressure range is excessive and there is reason to fear for the consequences to heart or brain, a diet composed of milk with cereal additions may exercise a very beneficial effect. In certain cases especially where there is an apparent toxic factor at work we see a certain vasomotor irritability which exposes the patient to sudden and severe accessions of pressure. Very suddenly 40 or 50 mm. may be added to a pressure already abnormally high. At such times the heart may struggle under its load or apoplexy prodromes appear. In nephritic cases these sudden hypersensitive crises are usually uremic in origin. In the face of such a difficulty a strict milk and farinaceous diet, or better, even a period of starvation, may become advisable, or we may with advantage follow the suggestion of Haig and enforce for the period of the pressure wave a diet consisting solely of bread and fruit.

4. Fluid restriction. The amount of fluid drink does not materially alter the blood pressure so long as the heart is functioning adequately. The extent to which the fluids are to be restricted should depend on the ability of the kidneys to remove water from the system. High tension is not uniformly accompanied by active urine excretion. A patient at present under observation has a total daily excretion of 630 Cc. with a systolic blood pressure of 245 mm. Such instances are not rare. When the urine is abundant water may be permitted freely, and when the excretion rises to 2000 Cc. or higher no restriction of fluids is needed. With a low urine output some parsimony in fluids is indicated, the amount permitted corres-

ponding roughly with the capacity of the kidneys to remove it. When signs of cardiac insufficiency make their appearance fluid restriction should invariably be enforced. The physiologic amount under this latter circumstance may be placed at from 1000 to 1200 Cc.

5. Salt restriction. Certain care in this detail is advisable in high pressure cases. In strictly limited amounts salt will do no harm in cases where good cardiac function, and as it adds greatly to the palatability of food it may be permitted within certain limits. In excessive amount salt is a circulatory stimulant, and as it increases tissue lymph and adds to the viscosity of the blood it tends in consequence to raise blood pressure. It is well in all cases to instruct patients to avoid the use of salt on the food after it is cooked and served. If edema, however slight, is present salt should be excluded entirely from the diet.

THE VALUE OF THE LEUCOCYTE COUNT IN ACUTE SURGICAL DISEASES.—By Herbert W. Hewitt, M. D. Within the last decade leucocyte counting in acute surgical diseases has acquired a new meaning, due largely to the recognition of the value of the differential count. For many years total counts only were made, and these yielded but little information, as their significance was not well understood. An ordinary furuncle might produce a high count, while a severe general peritonitis might reveal a leucopænia, and these facts could not be satisfactorily explained. Since a more complete blood picture has been utilized in the study of this class of diseases, valuable information as to the diagnosis and prognosis has been made available. The limitations of all laboratory work, however, must be recognized. The laboratory alone cannot, save in exceptional instances, make a diagnosis for the physician. The clinical findings must be correlated with those from the laboratory, and this is especially true of blood work in acute surgical diseases. It is necessary to carefully exclude all other conditions which might cause a departure from the normal.

For the purpose of this paper it is essential to have, as a working basis, an average normal, not only of the total number of white cells, but also of the polymorphonuclear cells. As the polymorphonuclear cells are principally affected in inflammatory diseases, they alone of the various types will be considered. Various writers give the average number of leucocytes considered normal from 6,000 to 10,000, and the average normal percentage of polymorphonuclears from 60 to 80.

The differential count is of great value, since this is, as a rule, uninfluenced by physiological factors, and the changes due to the pathological conditions are more definitely defined. When both total and differential counts are taken and the relation each bears to the other is considered, the assistance rendered in the diagnosis and prognosis of the disease in question possesses a value vastly greater than either of the less complete and unrelated observations.

Surgery deals with general rules, and not with absolutisms, and there are exceptions to nearly all rules. The following statements, however, may be considered as general rules:

1. The total count is an index to the patient's resistance to the infecting organism.



2. The relative polymorphonuclear count is an index of the degree of the severity of the infection.

3. If we have a relative polymorphonuclear count ranging between 75 per cent. and 80 per cent., infection is probable; if between 80 per cent. and 85 per cent., infection is usually found; if above 85 per cent., infection is almost invariably encountered, and this regardless of the total number of leucocytes. In fact, some laboratory workers do not make use of the total count at all, but depend for diagnosis entirely upon the differential count.

#### CONCLUSIONS.

1. The laboratory findings must be correlated with the clinical to be of any value at all.

2. The total count alone is insufficient.

3. The differential count, *per se*, is of value in diagnosis, but of little value in prognosis.

4. The total and differential counts, when taken together and correlated with the clinical findings, are frequently of great value both in diagnosis and prognosis.

5. No definite percentage of polymorphonuclear cells can be taken to positively indicate infection. If we have a percentage of between 75 and 80 of polymorphonuclear cells, infection is probable; if we have a percentage of between 80 and 85, infection is usually found; if we have a percentage above 85, infection is almost invariably encountered.

6. The negative value of the count is sometimes very useful in diagnosis.

7. The duration of the infection must be taken into consideration.

Counts are more positively diagnostic when taken early in the course of an acute surgical disease. Infection will frequently, when of long duration, overcome the patient's resistance and so vitiate the value of the count. —*Annals of Surgery*.

THE TOXIC ACTION OF DIGITALIS ON THE HEART.—Bailey discusses this topic in the *American Journal of the Medical Sciences* for August, 1911, and reaches these conclusions:

1. Toxic effects of digitalis and related bodies may be divided into three periods with regard to their occurrence and severity. These toxic symptoms may usually be discovered in their earliest stages by careful and frequent sphygmographic observations: (1) Period of vagus stimulation; (2) period of depression of conductivity with masked vagus action; (3) period of marked muscular irritability with depression of contractility.

2. Digitalis heart block may be differentiated from ordinary heart block and from vagus influence as a causative factor.

3. Muscular irritability may be the first symptom observed, the other stages being short in duration and easily overlooked.

4. Irritability from digitalis must be differentiated from the progress of the disease by careful observation of the different functions as evidenced by combined tracings.

5. With therapeutic doses the rise of blood pressure due to vasocon-

striction is so slight that it may be disregarded, but with toxic doses it becomes of extreme importance.

6. Cumulation occurs with digitalis and may last for a considerable period.

7. Vomiting is probably a central effect of digitalis and is a sign that absorption is occurring.

8. Pulsus alternans may be relieved by digitalis in some cases.

TREATMENT OF FURUNCULOSIS.—Dr. H. K. Gaskill (*J. A. M. A.*, April 15), says the average of furunculosis under proper antiseptic condition will cure itself in from one to four months, but any method that will give relief in a few days is of course welcome to the practitioner to say nothing of the patient. He enumerates the usual causes of the condition and says that the urine should always be carefully examined for albumin and sugar and the patient warned against any predisposing or exciting factors. When there is no constitutional cause found he recommends the following line of treatment.

The end of a wooden applicator is sharpened to a fine point, wrapped with a small piece of raw cotton and dipped into pure phenol. This is inserted carefully where pointing occurs, held for a few seconds to allow the phenol to produce its anesthetic effect and then very gently pushed into the cavity, extreme care being used not to injure any limiting membrane or puncture a blood vessel. After an opening has been made sufficient for drainage an ointment of salicylic acid, from 40 to 60 grains to the ounce of petrolatum, is to be applied twice daily. At the same time the first injection of staphylococcus vaccine is to be used, 100,000 to 1 c.c., and after four days the second injection of 250,000. The subsequent injections, usually two, should be of 1,000,000 and a week apart. He prefers to inject in the loose cellular tissue between the scapulae and to precede it by dry cupping to cause a more rapid absorption. He has always used stock vaccines with satisfaction and is a little dubious as to the greater value of autogenous ones.

RADIUM IN THE TREATMENT OF GOUT AND RHEUMATISM.—W. His (*Deutsche Medizinisches Wochenschrift*, February 2, 1911, page 233), in an address before the Berlin Medical Society reported his experience with radium in the treatment of 100 cases of chronic rheumatism and 28 cases of gout. Of the cases of rheumatism, very marked improvement was obtained in about half the patients. In a much larger number of cases, considerable improvement resulted, while five cases were completely cured. All the cases had been severe and had received other forms of treatment without success. The best results were obtained in cases which had not lasted too long. Several cases with severe muscular pains were favorably affected. Of the 28 cases of gout, 24 were markedly improved or cured and four only were not improved. The best method of distinguishing between chronic rheumatism and gout is the examination of the blood for uric acid. Venesection is performed and 100 c.c. of blood are taken for the purpose of examination. The action of radium upon the amount of uric acid in the blood is most striking. Within a few weeks, in rare cases, within a few days the blood becomes free from uric acid. Usually this

diminution in the uric acid ran parallel with the clinical improvement, although there were some exceptions to this rule. The best method of applying radium is to have the patient inhale the emanations mixed with air for two hours daily. Another method is the injection of radio active solutions into the region affected. The mode of action of radium is not well understood, but it seems to modify metabolism in some way. Radium is not a panacea in gout, and cases for treatment must be carefully selected. Old cases with ankylosed joints cannot be successfully treated. In rheumatism, there is no value in a special diet, while in gout, a diet free from purin bodies is useful.—*Med. Rev. of Rev.*

**AFRAIDS.**—Afraid to be alone, Lycopy.; afraid "to go home in the dark," Caust.; afraid of death, Acon.; afraid of ghosts, Hydsc.; afraid of hobgoblins, Lach.; afraid of salvation, Sulph.

**SCOPOLAMINE IN NORMAL LABOR.**—Wallace in the *Liverpool Medico-Chirurgical Journal*, states that scopolamine will relieve the pain in labor without interfering with the force and frequency of labor pains. It seems to possess also some power of softening or relaxing the soft passages.

To obtain these beneficial effects it is necessary to pay close attention to dosage and to the time and method of dosage. To give a hypodermic injection of scopolamine, and thereafter to leave the patient to her own devices, or in charge of a nurse, is only to court failure and disappointment. Scopolamine is somewhat uncertain in its effects, and the dose that proves sufficient for one patient may not appreciably affect another, or may produce a condition of narcosis in which uterine contractions are weakened in force and diminished in frequency. As in the case of most drugs, the effects of scopolamine are proportionate to the size of the dose.

1. An insufficient dose has little effect in allaying suffering, but it often seems to set up marked thirst.

2. The proper dose brings about a drowsy state, in which sensibility to suffering is dulled and the recollection of it abolished—i. e., a state of amnesia is produced. The result of such a dose is that the patient not only suffers but little from labor pains, but she has afterwards no recollection of the suffering. This is the desirable state of amnesia, which is the aim and end of the use of scopolamine.

3. A dose in excess of that needed to produce amnesia results in narcosis, in which uterine contractions are lessened both in power and frequency—an artificially induced inertia of the uterus, with consequent prolongation of labor.

It is therefore apparent that haphazard dosage cannot obtain the best results from scopolamine, especially as the desired amnesia is sometimes difficult to produce. The reason for this is that the amnesic zone is a narrow one, and the step from mere insufficient effect to narcosis is short, so that if too big a dose be given the amnesic stage may be so transitory as to escape notice. Success, therefore, depends on individual attention to each case; for, in short, the dosage is a matter of experiment with each patient. It is better to give two doses of gr. 1-100 than a single dose of gr. 1-50, or to follow the first dose of gr. 1-100 by two or three smaller



ones until the amnesic state is attained, after which its maintenance is an easy matter. This is the crux on which success depends, and the neglect to observe it has been responsible for some unfavorable comment on the drug and its uses.

*The Dose.*—Experience has shown that the minimum first dose of any value is gr. 1-100. Tablets of this strength are prepared; roughly, each is equivalent to about 0.0006 gramme. Solutions of scopolamine do not keep well, but they are preferable when the drug is being used regularly, as the dosage is then more exact, and approximates precisely to that employed by observers who have made a study of the subject. A solution of which ten minims contains 0.0003 gramme (i. e., about gr. 1-200) is a convenient one to use. With the first dose of scopolamine is given morphine 1-12 to 1-6, but subsequent doses of scopolamine do not usually require the addition of morphine.

*Time of Administration.*—Scopolamine may be given either during the first or second stage. When administration is begun in the first stage, care must be taken that the initial dose is not given too early. The pains should first have acquired their characteristic rhythm, or, in plainer language, labor must be in full swing. In the case of a primipara whose uterine contractions are irregular and very painful, the use of scopolamine may give relief, but it will certainly delay the labor. Apart from this, the time at which the drug is administered seems to matter little, except that, of course, there is nothing to be gained by giving it at the close of the second stage, as the child will probably be born before any effect is noticeable.

*Method of Administration.*—This is, of course, hypodermic, with the usual aseptic and antiseptic precautions. A dose of gr. 1-100 is given, let us say, to a primipara whose os is three-fourths dilated. Immediately afterward some article in the room is shown to her, say a cup ornamented with a distinctive pattern. She is asked what it is, and replies "A cup." To the question whether she would know it again she says "Of course." At the expiration of half an hour the same cup is again displayed before the patient, who now may be more or less drowsy, so that it is necessary to rouse her. If the amnesic condition has been attained, she may reply "It's a cup," when asked, but she will stupidly deny having ever seen it before—i. e., her power of recollection has become abolished. But if the patient not only names the article but recognizes it as something she has seen before, then the dose has been insufficient and a further one must be given, after which the cup is again shown her. In some cases several doses are requisite before the amnesia is definitely established, but the total amount rarely exceeds gr. 1-50.—*Charlotte Med. Jour.*

**VENESECTION IN THE PRE-ECLAMPTIC STATE AND IN THE COURSE OF ECLAMPSIA.**—Francois discusses this subject from an experience in twelve cases, in which he also used cathartics and transfusion. In two cases wherein typical prodromal symptoms existed an abstraction of blood amounting to 500 gms. was sufficient to remove all symptoms at once. In such cases we must not hesitate but must proceed as soon as typical symptoms appear. If this be done, not only the convulsions will be prevented but also hemorrhages and dangerous œdema. Also in cases where convul-

sions have already appeared it is possible to observe a distinct improvement in the general condition of the patient after venesection; frequently the convulsions cease at once. Sometimes a few attacks appear, but their intensity is much less and may gradually cease. It is possible to encounter cases in which an effect upon the convulsions after venesection may not take place. Here there is an especially serious intoxication of the patient. In these cases the blood pressure rapidly rises again after the venesection to normal or above. In such cases a second venesection is indicated. The coma gradually disappears after the blood letting; but clear consciousness returns mostly only after twenty-four hours. In some of the cases the coma continued but the patient became more quiet; here the coma disappeared only after two or three days. Diuresis is increased very rapidly after venesection, and at the same time the albumin disappears from the urine. In nine of the twelve cases the labor was spontaneous; if it be delayed the use of forceps or the metreurynter should be used. The author believes that the removal of the child is not sufficient to free the patient from the toxins present. Of the twelve children nine lived.

The objection that venesection weakens the patient too much and an infection is therefore more probable, could not be substantiated. All of the patients left the hospital well, in from twelve to fifteen days post partum.—*Abstr. Zentralbl. f. Gyn.*, 1911, 663.

THEODORE J. GRAMM, M. D.

THE DIAGNOSIS OF CRIMINAL ABORTION.—Tome, (Paris) says that criminal abortion, especially in the first three months, differs from the spontaneous occurrence in several particulars. Especially noteworthy is the long continuance of the loss of blood, the profuse, active hemorrhages, the retention of the placenta and finally the intensity and frequency of infective processes. If abundant or profuse hemorrhages are present, if the placenta is retained or if there are subacute conditions of infection, the uterine cavity must be disinfected and everything must be made aseptic which has been soiled by the infected hand. If circumstances allow the uterine cavity should be emptied by means of the hand. If interruption of the pregnancy took place in the first months the uterus has not yet reached sufficient size to permit the introduction of the finger, and a curette may be necessary. If serious symptoms arise after the emptying of the uterine cavity or if there is the possibility of perforation being present, the uterus should be extirpated.—*Abstr. Zentralbl. f. Gyn.*, 1911, 664.

THEODORE J. GRAMM, M. D.

PRODROMAL SYMPTOMS OF PUERPERAL AND POST-OPERATIVE THROMBOSIS AND EMBOLISM.—Michaelis reports seven cases of thrombosis. Six of them followed birth or abortion and one was post-operative. In two cases there was sudden death from pulmonary embolism and in one case pulmonary infarct, the author believes that there are certain premonitory signs of thrombosis and embolism and that they are shown by subfebrile temperature which are often overlooked because of inexact or too infrequent taking of the temperature. Thus the author only once saw in one case a slight temperature rise where the temperature was taken four times daily.

And yet this was doubtless to be regarded as the only indication of the coming thrombosis. In regard to the etiology of thrombosis the author believes that infection plays a great part. In addition there are all those causes which diminish the activity of the circulation in the veins, loss of much blood during labor, heart defects, etc. Many thrombi are probably only secondarily infected. The premonitory slight elevations of temperature probably indicate that a thrombus is present which does not become organized in the usual manner, but becomes softened and small particles become detached and pass into the circulation.—*Abstr. Zentralbl. f. Gyn.*, 1911, 690.

THEODORE J. GRAMM, M. D.

A NEW TREATMENT OF PHLEBITIS.—Fischer (Wiesbaden) treats these cases with a modified Unna treatment of leg ulcers. After applying zinc ointment to the inflamed parts he applies a tight fixed dressing. With this the patient may go about. The favorable effect of this dressing the author believes to be brought about by compression of the inflamed vein walls and the thrombus held fast so that it cannot pass onward in the circulation. The pressure soon causes the thrombus to soften and then to be absorbed by the greatly increased circulation induced by the dressing. Any particles tending to become loosened are held fast and the danger of embolism ceases. Cases in which the thrombosis extends along the veins into the abdomen are not suitable for this treatment, nor are those where the thrombus suppurates.—*Abstr. Zentralbl. f. Gyn.*, 1911, 692.

THEODORE J. GRAMM, M. D.

A NEW METHOD OF TESTING THE RENAL FUNCTION.—Wohlgemuth (Berlin). The fact that animals having normal kidneys are able to excrete more diastase than those whose kidneys are affected, has led Wohlgemuth to apply it in determining the functional activity of the kidneys. After having determined in dogs, in whom the pancreatic duct had been tied, that the amount of diastase excreted was the same from both kidneys, he examined the urine of patients obtained by ureteral catheterization. In them also the urine from both kidneys was the same in normal cases. When the kidneys were affected the amount of excreted diastase was much diminished. As compared with other methods of diagnosis it was shown that the diastase method was equal to krioscopy and far better than the phloridzin and indicarmin methods. Further advantages of this method consisted in that no foreign substances need be introduced into the body, and also that normally the excreted amounts of diastase vary within definite limits, so that determining the relative amounts in the collected urine is not necessary, but the absolute amount may be used in the test.—*Abstr. Zentralbl. f. Gyn.*, 1911, 696.

THEODORE J. GRAMM, M. D.

RADIUM IN INOPERABLE CARCINOMA OF THE CERVIX UTERI AND OF THE VAGINA.—According to Cheron and Rubens-Duval, patients affected with inoperable cancer of the uterus cannot at all be regarded as lost if the extension of the carcinoma into the posterior vaginal vault and into the ligamenta lata is not too extensive. These cases may still be very effectively



treated with radium, and thereby a condition induced in which they may yet be very well operated. In cases still appearing to be operable the knife, must of course, be used. It is a question, however, whether an after-treatment with radium is not very advantageous in order to prevent recurrence. It is to be recommended in cases of uterine cancer in order to impede progressive growth of the cancer, before operation. In undoubted inoperable cases a favorable result is only to be expected from the use of radium. On the other hand, in cases in which the possibility of operating appears doubtful, the radium treatment is unquestionably indicated. The results from its use are that the neoplastic masses retrograde, they change to firm, connective tissue and the ulceration heals. The use of this treatment is in no respect a loss of time. Its main advantage consists in that the tumor does not contain any bacteria after this treatment, is poor in vascular supply, is diminished in volume and is not so fragile. From this alone the possibility of operating is much increased. Curetting the tumor is only indicated when the proliferation is extensive. Large masses are thereby removed, and it becomes possible to reach the base of the growth and the action of radium is made more effective. Since curettage is almost always associated with much hemorrhage, the latter may be much diminished by the previous use of radium, whereby the tissues are made anæmic.—*Abstr. Zentralbl. f. Gyn.*, 1911, 734.

THEODORE J. GRAMM, M. D.

BLOOD COAGULATION AND COAGULATING SUBSTANCES IN ECLAMPSIA.—Those who are inclined to accept the theory of Dienst concerning the etiology, and it must be conceded that all the lesions of eclampsia are explained thereby, will be interested in some apparently adverse results of experiments conducted by Cristea and Bienefeld. These authors have endeavored to determine the coagulation time of the blood of eclamptics as compared with pregnant and non-pregnant women and also the amount of fibrogen and fibrin ferment. They found that the coagulation time of the blood of eclamptics as compared with that of the other women was neither increased nor retarded. The quantity of fibrinogen and fibrin ferment was the same in both classes of cases. The occurrence of the eclamptic attack does not depend upon the pains of labor, but may take place before their onset. Eclampsia cannot be an anaphylactic occurrence, because coagulation is normal. Post-partum hemorrhages have nothing to do with the coagulability of the blood.—*Abstr. Zentralbl. f. Gyn.*, 1911, 663.

THEODORE J. GRAMM, M. D.

DIAGNOSIS OF CARCINOMA BY MEANS OF URINALYSIS.—Salkowski has found that the nitrogen content of plumbic subacetate precipitate amounted to 1.22 per cent. of the total nitrogen in normal cases, while in the urine of the cancerous it amounted to 3.03 per cent. as the average of ten examinations. The highest amount found in cancer was 4.62 per cent. The greatest amount in normal cases never reached the minimum amount in cancer. Whether this high relative nitrogen content of the precipitate is actually pathognomonic of cancer, must be demonstrated by control tests in other diseases.—*Abstr. Zentralbl. f. Gyn.*, 1911, 734.

THEODORE J. GRAMM, M. D.

**THE CRY OF SYPHILITIC CHILDREN.**—Sisto says new-born children cry from pain or from hunger. Among the pains which come into account are especially to be named those caused by hereditary syphilis. The causes of these pains appear to be located in the region of the epiphyses of bones. The syphilitic cry or whimpering is distinguished from other cries by its continuance, its intensity and its being always the same. This cry is occasionally the only symptom of hereditary syphilis. In other cases of hereditary syphilis these cries may be observed in other pathological changes of syphilis. They disappear after anti-syphilitic treatment, sometimes with remarkable rapidity.—*Abstr. Zentralbl. f. Gyn.*, 1911, 731.

THEODORE J. GRAMM, M. D.

**CALCIUM LACTATE IN THE THIRD STAGE OF LABOR.**—Ansems gave three grammes of calcium lactate daily to five pregnant women who in former pregnancies had severe hemorrhage after labor, and continued the treatment for from five days to four weeks. The result in all cases was that the amount of blood lost was remarkably small. In another case of molar pregnancy the same result was observed. The remedy was without effect in a case of threatened abortion.—*Abs. Zentralbl. f. Gyn.* 1911, 130.

THEODORE J. GRAMM, M. D.

**HYDROCYANIC ACID.**—A remedy for society and hysterical women. Severe pains are felt in the pit of the stomach radiating out in every direction. Many of the symptoms complained of by patients rest upon a hysterical or neurasthenic basis. If the case is a severe one, great restlessness, then thirst, are important symptoms. A gurgling sound is heard upon drinking water, followed by unconsciousness. After the stomach's contents have been vomited the patient returns to consciousness.

**NUX VOMICA.**—When this remedy is given for the relief of gastric disorders it will act very quickly if given in hot water. In acute cases calling for its use 2 or 3 tablets of the second decimal trituration may be dissolved in a glass of hot water. This dose to be repeated every hour.

**DULCAMARA.**—Eruptions appearing on the faces of young girls—and old ones, too, for that matter—just before the menstrual period, are cured by dulcamara. This symptom has seen frequent verification.—Albert E. Hinsdale, *Medical Century*.

**ALUMINA.**—Dryness, numbness, and weakness are three of the most important symptoms in the symptomatology of alumina. Patients are worse in a warm room, in bed, in the evening and during rest. Alumina patients are spare, thin, dark complexioned. Some of the indications calling for alumina are apt to be found in girls at the age of puberty.—*October Century*.

When at a standstill in heart cases do not be afraid to "try" *cratægus ox.* in 5 drop doses of the tincture. It is not a poison like digitalis, nitro glycerine, etc.—*October Century*.

## Monthly Retrospect

### OF HOMOEOPATHIC MATERIA MEDICA AND THERAPEUTICS

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CONDUCTED BY A. LEIGHT MONROE,

Miami, Florida.

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THE THING BEHIND THE MASS OF SYMPTOMS.—“But there is one other general—the greatest of them all—which I must not omit, for it is created by the blending of all the generals and particulars into one harmonious whole. For lack of a better word we speak of, let us say, the ‘sepia’ constitution, meaning thereby that special diseased condition of mind and body for which that remedy has so often proved itself curative, that we come to look upon it almost as an entity. At times it is plainly discernible by all, and capable of being described in words, such as the leuco-phlegmatic constitution of calcarea, the tall, thin, narrow-chested one of phosphorus, or ‘the lean, stooped, ragged philosopher,’ as Hering called the sulphur patient; but far oftener it is something much more subtle, such as that of arg. nit., with its fears and anxieties and hidden, irrational motives for all it does. To very few of us is it given to penetrate into these secrets and to understand that almost indefinite something which often lies behind the mere symptoms, modifying and characterizing them all, and so becoming the governing elements in the whole case. The masters in our art are those who have had the power to understand this great general, and we stand amazed at their skill in penetrating right into the heart of the most complex cases and evolving order and consequent cure out of seeming chaos.”

(NOTE.—The name of the journal in which the article from which the above was clipped, and of the author, is lost, or, rather, was not taken at the time, hence the omission of proper credit. It contains a noteworthy point.—Editor of the *Homoeopathic Recorder*.)—*Hom. Recorder*, Sept., 1911.

WHAT TO DO FOR THE NERVES.—Chorea. The brevity of this paper forbids mention of inferior, though a properly indicated class of remedies. It is to the leading, best proven remedies we direct your attention. The question arises, what is chorea?

Dr. Wilson in his medical diagnosis, page 1369, says, “It is a disease of children and young adults characterized by continuous, irregular, involuntary muscular contractions and physical derangements.” He affirms that certain abnormal muscular movements found in adults, particularly, and defined as choreiform are not really and truly chorea. This may be true from the standpoint of the materialist but not from a true therapeutics premise. There is no pathology in chorea other than the visible contractions and



jactitions of the muscles. These peculiar muscular abnormalities are due to nerve disturbances. Thus far we have been unable to learn the nerve changes which cause these muscular contractions. We are therefore left to conclude that chorea is, primarily, a nervous disease peculiar to childhood and the period of adolescence and is found more frequently in the female. The etiology, symptomatology, classification, etc., cannot be noticed in this paper. We therefore turn to a study of the therapeutics of chorea. We propose to classify our remedies in two divisions: first, those remedies whose pathogenesis have shown marked development of nerve disturbances called chorea. These remedies are *actea racemosa*, *agaricus*, *belladonna*, *calcareae carbonica*, *causticum*, *cicuta*, *cina*, *cuprum metallicum*, *stramonium* and *tarantula*.

Those of the second class are more numerous and often indicated, yet do not carry the high percentage of affinity for the nerve disturbances in question as does the first class. Those of the second class are *amyl nitrite*, *antimonium tartaricum*, *argentum nitricum*, *artimisia vulgaris*, *asafoetida*, *atropine sulphur*, *bufo*, *cactus*, *cedron*, *cheledonium*, *cocculus*, *codein*, *crocus*, *ferrum*, *formica*, *gelsemium*, *hippomanes*, *hyoscyamus*, *ignatia*, *iodin*, *kali bromatum*, *kali sulphuricum*, *laurocerasus*, *lilium tigrinum*, *magnesia phosphoricum*, *morphine sulphuricum*, *mygale*, *natrum muriaticum*, *nux moschata*, *nux vomica*, *opium*, *phosphorus*, *rhys toxicodendron*, *silica*, *sinapes*, *sulphur*, *sumbucus*, *thuja*, *veratrum viride* and *zincum*.

Brevity necessitates the mention of the leading characteristics only. These characteristics are perfectly reliable and must not be forgotten.

In *actea racemosa* the muscular twitchings are confined predominantly to the fingers and toes, there is some nervous shuddering over the upper and back part of the body and some trembling of the limbs, but the choreic affections are confined predominantly to the fingers and toes.

*Agaricus* has involuntary motions and jerkings of single muscles extending at times to jerking of the whole body. The point to be remembered is that these twitchings and jerkings cease during sleep.

In *belladonna* we have marked bodily inquietude. The patient must be on the go, if he does not move around from place to place he must keep his body or some members of the body in constant motion. The twitchings, however, are confined more particularly to the arms and face, causing difficult articulation and throwing the head back with a rolling motion from side to side.

In *calcareae carbonica* the choreic conditions are usually associated with faulty dentition, the twitchings are sometimes only one-sided, there are involuntary motions, sometimes falling down, violent motions of the hands and the feet resulting predominantly from fright, onanism or worms.

In *causticum* the choreic twitchings or jerkings are constant day and night, confined largely to the right side of the face, producing more or less paralysis of the tongue; or we may find the child lying on its stomach with one knee inserted in the hollow of the other and the feet drawn on its buttocks and in this position the child is constantly squirming, jerking and twisting.

*Cicuta* covers a multitude of nerve disturbances. In chorea we have this peculiarity; the attacks twist the child into furious and frightful contortions compelling it at times to scream.

In *cina* we have choreic movements resulting from worms. The distortions, however, often begin with a shriek, extend to the tongue, œsophagus and larynx, continuing even through the night causing a peculiar clucking sound in the throat.

*Cuprum metallicum* is full of nervous twitchings, spasms and convulsions. Thus we have twitchings and jerkings which commence in the fingers, the attacks often affect only one side, they are painful and spread over the whole body; or we may have periodical choreic muscular contractions with laughter, grimaces, exaltation and ecstasies, irregular movements commencing in the fingers and toes, and, as before, twitchings confined to one side and are relieved by lying down. Then again, there are involuntary motions of the left arm and leg resulting from fright and finally developing into chorea so that the child is unable to keep the limbs quiet while awake, the control of the tongue is lost and speech is absolutely absent. The most important point is this: the attacks begin with shooting and burning pains particularly in the left arm, the arm is convulsed, tossed about so that the whole body has to follow, horrible distortions of the eyes and face, the neck is drawn to the right shoulder, face is red and sweated, fever and thirst; and the attack ends with making fun, such as creeping under the table or under the bed, peculiar irritable changing from a mild, sentimental mood to a most stubborn obstinacy.

*Stramonium* has twitchings of the hands and feet, of the tendons, of the extremities and throughout the whole body. Choreic attacks are often preceded for some length of time by great irritability and sensitiveness, inclination to weep alternating with laughter and sprightly humour, trembling in one or more extremities, the movements of the extremities are performed with ease and with force, except that walking often degenerates into a hurried running. These things are found in persons of a weakly constitution with increased action of the nervous system. Choreia resulting from fright, creeping in the limbs, then violent movements and these movements are generally cross-wise, maybe of the right arm and the left foot, they rotate the arms over the head, they jump, climbing over tables, run hither and thither. In chorea resulting from fevers or cerebral disturbances we often have rapid and involuntary motion of the tongue with impossibility to utter a word, in attempting to pick something up from the floor or table the hands will often go in the opposite direction from which it is intended. When the tongue is not impaired *stramonium* has, as a rule, great loquacity.

*Tarantula* is possibly more frequently indicated in choreic affections than any other remedy, for we have found in its pathogenesis the remedy full of nervous twitchings, jerkings, agitation, restlessness with constant irregular movements of the arms and limbs, the child is often unable to feed itself; speech is difficult, the tongue is heavy; often starting and jumping in sleep, there are often hideous grimaces, violent contortions of the body, every effort to take food causes involuntary movements of the tongue. Though the trouble is not so severe at night the child can sleep but a few moments at a time. In each and every instance not one particular symptom but the totality of symptoms constitute the case.

Since we have given the leading remedies in this affection we will let the reader study those of the second class as occasion may require, for

space forbids entering upon their discussion.—G. E. DIENST, *November Critique*.

**REMEDIES FOR MENTAL DERANGEMENTS.**—Mania and Delirium. Melancholia.—*Actea Racemosa*. The first remedy for melancholia will be the last we gave for acute mania or delirium, but we have a different group of symptoms to combat. Several of the remedies in the first class will be found in this and the other classes, but in each case presenting a different picture. In the melancholia of actea we have gloom as if a black pall hung over everything; it feels as if her mind were wrapped in a heavy black cloud; feels sure she is going crazy; fear of death, impatient, i. e., feels hurried; impelled to run (I had an actea patient run 12 miles in two hours on a hot July day without being the worse for it); incoherent ideas, irritable. The characteristic modality is aggravation at times of menses, which menses are irregular and scanty. For this condition I find the 3rd the best. The actea patient is plump, well developed, dark.

*Nux Vomica*.—Hypochondriac, after eating, when affected by the slightest provocation; ill-humored; quarrelsome even to violence; sensitive to impressions on the senses, such as noise, odors, bright light, etc.; greatly affected by music and singing; howls, scolds and weeps; dread of any mental exertion; headache, dull, sore as if beaten; constipation with frequent ineffectual urging. For persons of sedentary habits, dyspeptics, alcoholics, and brain workers. Since strychnia phos was proven I use it in the 6th to 30th instead of nux for brain workers with the above symptoms. 3rd to 200th.

*Natrum Mur*.—Sad, weeping; the more you attempt to console the patient the worse he becomes; apprehensive, disheartened; with palpitation of the heart; sad, and desires to be alone; disinclined to work; angry at least provocation; pulsating headache in vertex; mental weakness, cannot grasp ideas; late in falling asleep; anxiety about the future; revengeful toward those who have formerly given offense. Aggravations are: Mental exertion; in the morning; after sleep; by eating; from 10-11 A. M. Like pulsatilla the natrum mur. patient craves fresh air and is better in it; the melancholia is that of anæmia. It is often useful after intermittent fever, especially useful for chlorotic girls. I have never received any benefit from it below the 30th. Good from 30th up.

*Pulsatilla*.—Weeping; irresolute; ill humor, in the morning when thinking of their work; disgust for everything; anxiety; longing for first one thing then another; morose at times and easily put out of sorts; envious; capricious; absent-minded. The pulsatilla patient's mental symptoms are always relieved by fresh air, being out doors. Cheerful companions also can do much for them, also a good nourishing diet. The melancholia most frequently takes on a religious nature. The ideas are fixed. Gastric and mental disorders due to catarrh are the causes. The patient is always worse in the evening; in damp, gloomy weather; in a close room; from heat; hot weather; from rest and from pastry and fat food. I have never received benefit above the 3rd unless I went to the 1000th.

*Sepia*.—The sepia patient is thin, spare, sallow. She is completely indifferent to everything which should interest her, her household work, her society duties, her children, herself; suicidal tendency from despair;



apathetic; sad, weeping; fault finding; ill humored; menses late and scanty; bowels sluggish; sleepy; a dragging, bearing down sensation in stomach, abdomen and pelvis; may be roused up or excited by company or other means, but soon relapses in her melancholic condition. Dose 30th, 200th and 1000th. The sepia patient needs a generous diet of such food as will help regulate the bowels, and large quantities of water. Massage and electricity are both helpful.

*Arsenicum Alb.*—Despairs and weeps; imagines he must die; anguish, with tossing about from place to place; dread of death when alone or on going to bed; fear of ghosts, of solitude and death; fear, with at times indescribable melancholia; disposition to suicide; and attempts at same; extreme restlessness and physical weakness; hurried in all his actions especially eating and drinking. The general modalities of the drug, viz. aggravation after midnight, from cold and damp and out of doors. Amelioration from warmth. The irritability of the stomach is also marked in this condition. The conditions calling for this remedy are those following acute prostrating diseases. Potency 6th to 1000th.

*Aurum Met.*—Disgust for life; anguish increasing unto tendency of suicide; longs for death; easily angered; irritable; and quarrelsome; sad, imagines he will never succeed at anything; apprehensive and fearful lest some one should come into his room and discover his sad plight; weeping; howls, screams and imagines herself a lost soul, morose; anxiety, loquacity; continually asking questions without waiting for an answer; nightly aggravation is the characteristic modality. Syphilitic and mercurial poisoning most frequently cause the above symptoms. 12th and 30th.

*Ignatia.*—Sensitiveness; delicate consciousness; angry at slightest blame or contradiction, then angry at herself; impatient; irresolute; changeable mood, but usually lachrymose; howls, cries and scolds if her orders are not obeyed; now and then hysterical when she may laugh in alternation with her weeping; all attempts at consolation aggravate her real or imaginary grief; frequent and deep sighing; globus hystericus; frequent desire to urinate and as a rule painless diarrhea. The two most frequent causes are depressing emotions and dyspepsia. 30th to 200th.

*Lilium Tig.*—Hurried feeling, as if imperative duties, and an inability to perform them, accompanied by sexual excitement; depression of spirits; inclination to weep, with apprehension of suffering from some internal disease; aversion to being alone; restless sleep; worse before midnight; inability to sleep, with wild feeling in the head; menses late and scanty; bearing down sensation in the uterine region as if everything would protrude; heart feels as if pressed in a vise, waking the patient suddenly; interrupted pulsation of the heart; diarrhea on waking in the morning, with griping in abdomen and soreness in rectum and above anus. Melancholia of nervo-bilious woman suffering from prolapsus uteri. 3rd, 6th and 30th.

*Lycopodium.*—Sadness all day, with weeping and discontent; sadness in the evening, with confusion of head; weak and despondent; apprehensive when walking in the open air; disinclined to talk; confusion about every day affairs; speaks wrong words; loss of sexual power in the male; constipation; sallow skin; variable appetite; enlargement of the liver; drowsy after meals but wakeful at night. This is our great remedy for melan-

cholia due to hepatic derangement. I have derived the most benefit from the 30th and 1000th.

**MANAGEMENT OF POST-PARTUM BLEEDING.**—After every labor, F. Heiman carefully observes the position of the fundus. If no bleeding occurs, the hand is pressed in over the symphysis half an hour after birth, to see if the umbilical cord recedes. If this is the case, the placenta has not yet separated, and expression is performed in 3 to 4 hours. If the placenta is free in the vagina, slight pressure upon the fundus will usually expel it. In case of bleeding, it is important to note the character of the blood. If arterial and of intermittent flow, a tear is likely. Immediate repair is necessary after expression. If the blood flows more continuously and is venous, the uterus will be relaxed and there is imperfect separation of the placenta and atony massage of the womb should be tried, later, Credes' expression, if necessary in narcosis. If this is ineffectual, the placenta must be removed manually under narcosis. Retention of the membranes alone usually is no cause for interference. If the placenta is out and the bleeding continues, the injection of secale and hot or cold douches will almost invariably check it. Numerous other methods have been suggested but the author has never found it necessary to resort to them. Thus, tamponade of the uterus is practiced by some, others bend the uterus over the symphysis, turn it spirally or compress it with special instruments. The subcutaneous or utero-muscular injection of adrenalin has been recommended as well as the application of a rubber bandage around the waist. Concerning the latter, the opinions are divided. As a last resort, vaginal or abdominal hysterectomy may be practiced, but it is clear that an exsanguinated woman would only rarely recover after so severe an operation.—*Muench. med. Woch.*

**IBERIS AMARA AND CRATAEGUS OXYACANTHA: THEIR DIFFERENTIAL USES IN CARDIAC DISEASES.**—*Iberis Amara*.—The leading symptoms may be thus summarized:—

*General*.—Loss of strength; trembling sensation throughout the whole body, especially the legs; is weak, nervous and exhausted on rising, with nausea and dizziness; . . . sleeplessness; . . . (restless night), with horrid dreams, etc.

*Head*.—Vertigo (in all three provers), . . . Slight dizziness while in the upright position, much increased by stooping . . . dizziness in back part of head, as if the occiput were turning round. . . . Severe frontal headache, nausea, and loss of appetite.

*Throat*.—Dryness of fauces; hawking up of viscid, stringy mucus. . . choking sensation in throat.

*Respiration*.—Respirations more frequent and laboring; considerable dyspnoea, with stabbing pains through the heart.

*Heart and Pulse*.—A constant dull pain in the heart; sharp pains through the cardiac region (compare symptoms 419 and 421 of *Spigelia*). . . . A peculiar symptom was No. 94 (Sabin): "On turning on left side, a sharp sticking is felt, as if a needle were crosswise in the ventricles, and pricked at each contraction." Symptom 100 is significant. . . . Slight exertion, as rising from a chair, coughing, or laughing, causing distressing palpita-

tion, with increase of the dull pain, which is constantly felt, at 10 a. m.; (102) heart's action weak and fluttering at 11 a. m.

In all three provers there was a great increase of both heart and pulse rate. In the woman, whose pulse was normally 65 to 70, it rose to 96, fifteen minutes after the first dose of the 1x tincture, subsiding to 60 in seven hours. In the same prover we have: pulse 98, regular and full, fifteen minutes after second dose; great acceleration, irregular and jerking, with a peculiar thrill under the finger; after mother tincture, pulse rose from 70 to 90, and shortly afterward rose to 100, and became irregular. Prover No. 2 records: pulse 90, undulating, tremulous, twenty-five minutes after the 1x tincture; thirty minutes after the mother tincture, pulse 77, irregular, full; intermits regularly, sometimes at every third, at other times every fourth, fifth, or sixth beat; there is intermission of the heart-beats, which every slight exertion aggravates.

Prover No. 2, who started taking iberis with a touch of rheumatism in the left shoulder, experienced (symptom 110) "pain dull and heavy in left arm, commencing in tips of fingers with tingling and numbness." Tingling and numbness commencing in fingers of left hand, and gradually extending up the left arm. In all three provers iberis increased the ventricular contractions of the heart for several hours, and this effect was confirmed by Dr. Gatchell's experiment on frogs, in 1877.

A throat symptom was dryness of fauces; hawking up of viscid, stringy mucus.

*Stomach, Abdomen and Stool.*—Loss of appetite, nausea, and headache; sour eructations, fulness, oppression, tenderness over right hypochondrium; several thin, whitish, or clay-colored stools passed in quick succession. Here we have an important resemblance to digitalis.

On the urinary organs, this drug had no very marked effect; the female prover had, on the first day, "frequent but scanty urination; on the second day, urine excessive in quantity."

These provings clearly establish the claim of iberis to be a cardiac remedy of value, but there is a need for their extension. I am not aware of any later provings; but there is sufficient and increasing clinical evidence of its usefulness.

*Crataegus Oxycantha* is the well-known hawthorn.—No medicinal qualities were ascribed to the hawthorn until a certain Irish doctor, Dr. Green, of Ennis, took it up, we know not from what source, as a remedy for heart disease. His success was such as to spread his fame throughout Ireland. He kept the name of the drug secret, and after his demise, in 1893, his daughter revealed it as the berries of the hawthorn. *Crataegus* was adopted by the allopaths as a remedy in heart disease, chiefly as the result of a remarkable paper contributed to the *New York Medical Journal*, October 10, 1896, by Dr. M. C. Jennings, in which he described his uniform success in 43 cases of serious, often nearly moribund, cardiac disease.

Soon the homœopaths took it up, clinically, and I am able to adduce much more evidence of its power in this sphere than is possible in the case of iberis. The first volume of Clark's *Materia Medica* gives a good summary of what was then known of *crataegus*; but there was no pathogenesis, except the following observations of Dr. T. C. Duncan: "In my



proving of this drug it produced a flurried feeling, due, I thought, to the rapid action of the stimulated heart. One prover, a nervous lady medical student, gives to-day in her report, 'a feeling of quiet and calmness mentally.' This is a secondary effect, for it was preceded by 'an unusual rush of blood to the head with a confused feeling.'"

Clarke quotes three illustrative cases, and constructs his "symptoms" upon these, incorporating the above observations of Duncan. But Dr. Claud A. Burrett, in 1908, organized a test-proving at the University of Michigan, which has so enlarged our knowledge of *cratægus*, as to make our employment of it more definite—though still there is much to be discovered. Two healthy and robust young men, aged 21 and 23 respectively, proved *cratægus* by taking the 3x dilution for four days, the 2x for two days, and during the remaining eight days of the experiment, from 5 to 40 drops of the mother tincture. While taking the 3x and 2x dilutions no symptoms appeared. But on the evening of the administration of 5-drop doses of the mother tincture, prover No. 2 noticed attacks of dizziness, lasting a few minutes, while the pulse rate became lower, without change in its character, as shown by the sphygmograph.

Prover No. 1 felt no dizziness, but the pulse became slower and firmer. The normal pulse rate in No. 1 prover was 84, and in No. 2, 88. Under the larger doses of the mother tincture the pulse declined to 56, and became much weaker. At this point both provers suffered from air-hunger, and had the windows opened, though it was winter (December).

Dr. Burrett's commentary on the entire experiment is as follows: The action of *cratægus* is exerted almost entirely upon the heart muscle, and may be compared with *digitalis*, *strophanthus*, and *adonis vernalis*. . . . The action of *cratægus* is less powerful than that of *digitalis* or *strophanthus* and much more prolonged than that of *adonis*, which exerts its action through the heart nerves. It would seem to be best indicated in subacute or chronic heart cases where the effect upon the heart muscle is desired.—DR. JOHN MURRAY MOORE, *British Homoeopathic Journal*.

ARTERIO-SCLEROSIS.—Jno. P. Sutherland (*New England Med. Gazette*). Unfortunately the records of drug pathogenesis do not establish for us as a rule definite pathological pictures, but it is the consensus of opinion that the metals are particularly prone to produce inflammation and degeneration of interstitial and connective tissues, and if this is so we ought to look to the metals for our most effective pharmaceutical agents with which to combat the effects of arterio-sclerosis. Among these preparations, following lead, reference must be made to mercury which in small doses and continued for months at a time may have an alterative effect upon sclerotic tissue. Among other metals the use of which is indicated by its pathogenetic effects is *aurum metallicum* (or *aurum muriaticum*, or the double salt, *aurum et natrum muriaticum*), which has long been held in high esteem in the treatment of conditions which to-day are recognized as concomitants of arterio-sclerosis. *Baryta*, especially in the iodide, and *strontium iodide* promise to be useful agents, although their use at the present time would seem to be based upon clinical reputation rather than observed pathogenetic effects.

How about the tissue remedies?—(Ed.)

# THE HAHNEMANNIAN MONTHLY.

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## A PLEA FOR THE SURGICAL TREATMENT OF HERNIA.

BY

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(Read before the Homoeopathic Society of the County of Philadelphia, December, 1911.)

THAT a person afflicted with some form of abdominal hernia is in constant danger of fatal complications, particularly if an active life is led, is a fact recognized by all, and needs no argument from us in its support. This being true, it only becomes necessary for us to determine the best way to rid the endangered individual of his or her complaint and proceed to apply the remedy without any delay. The radical surgical operation for the cure of hernia is not the only method of treatment, by any means, but to our mind, it is the best method, and should be given first place over all the others.

All hernias are not suitable cases for operation. Any individual who is not a good surgical risk is not a suitable case. Any hernia which is of great size, which has been irreducible for a long time, in which the muscles and fasciæ have been stretched and thinned by long pressure, which has been the seat of repeated inflammatory attacks, is not a good case for operation. True, surgeons operate under these conditions, but the operation becomes then a choice of the lesser of two evils, and the chances for a cure are minimized. The point that we desire to make is that too many cases of hernia are treated by inadequate methods, are allowed to increase in size and bulk, and are

neglected until there is either great discomfort, or threatened or actual strangulation, and are then subjected to a late operation under unfavorable anatomical conditions that offer but meagre chances for a cure. The slogan for the modern treatment of appendicitis is operate early, if you wish to save your case. Operate as soon as the diagnosis is made. We believe this is also applicable, in a large measure, to the wise management of abdominal hernia.

When we consider that the majority of abdominal hernias are actually due to an error in development, we can readily understand the wisdom of the surgeon coming to the assistance of nature to remedy the defect as soon as possible, before retrograde changes take place in the parts involved, that will seriously impede his efforts, and probably ruin the patient's chances for a permanent cure.

In order to illustrate my point let us consider briefly inguinal hernia, which constitutes the great majority of all the forms of abdominal hernia.

When the testicle begins its descent about the fourth month of foetal life, it is preceded into the scrotum by a process of peritoneum; viz. the vaginal process. The testicle reaches the abdominal wall at the internal ring by the fifth or sixth month, and then enters the inguinal canal, passing into the scrotum during the eighth or ninth month of foetal life. During its descent it occupies a position back of the peritoneum and posterior to the vaginal process. The latter is present as a patulous canal at the time of birth, most authorities stating that soon after birth the vaginal process becomes occluded, first, at the internal ring, and thence downward until the testicle is reached, where the occlusion ceases, leaving a peritoneal sac to form the tunica vaginalis testis. In the female the same development is observed excepting that the round ligament takes the place of the testicle and cord. It is right here then that errors of development occur. The vaginal process, instead of being occluded, may persist in part or in whole, inviting the abdominal contents to fall in, or it may become occluded only at the internal ring, the thin covering being easily pushed downwards by intestine or omentum. Or two processes of peritoneum may extend into the scrotum, one obliterating and the other remaining patulous. A classification of these forms of hernia due to developmental defects is not necessary in this paper, as they are known to all of you. The term congenital hernia applied to them should not



lead one to suppose that they necessarily exist at birth, as they frequently do not make their appearance until later, but the defects that lead to the escape of abdominal contents exist from birth. A late appearing congenital hernia is said to show itself suddenly, without much pain, and immediately pass into the bottom of the scrotum, always presuming, of course, that the vaginal process remains patulous, at least to the testicle.

From observations made at the operating table on our cases of hernia, and also in cases operated by other surgeons, where we have been present, we are strongly of the belief that practically all cases of oblique inguinal hernia are of the congenital type, some defect of development being always noted. Direct inguinal hernia we have seen very rarely, and we cannot recall ever seeing one in a young subject. (Hernia of bladder is almost always direct.) R. Hamilton Russell, of Melbourne, claims that all cases of inguinal and femoral hernia, with the possible exception of some cases of direct inguinal hernias, are due to the presence of preformed pouches of peritoneum in the inguinal and femoral canals, and strengthens his position with much original and convincing evidence. His researches have been the most important in elucidating this mooted question, and his arguments are very interesting.

The same observations hold true in regard to umbilical hernia. True congenital umbilical hernia we have seen only in the text book. Infantile umbilical hernia is a defect in development. If it persists, it should be remedied by early operation, particularly in female children well before they reach the child bearing period. Many cases of large, so-called "acquired" umbilical hernia with all their discomforts and dangers could be readily prevented by an early operation, the simple suture of the umbilical opening being but an insignificant surgical procedure compared to the dangerous and complicated operations necessary in later life.

In femoral hernia operation is always indicated, as there is no possibility of a cure being obtained from the truss treatment, and this style of hernia is particularly prone to strangulation. We do not desire at this time to consider the varied forms of hernia, but will confine ourselves to the varieties already quoted, and attempt to make out a case in favor of early operation. What are the chances of obtaining a permanent cure by the radical operation? We will answer this question in brief by a consideration of two factors, namely, the published

percentage of cures, and the mortality rate of the operation. The ideal surgical perquisites are, an individual in good physical condition, and of sound organs, and a moderately sized hernia of relatively short standing, which has not been the seat of any irritations. These conditions are but seldom encountered, and mainly because patients usually reach the surgeon after having made long trials of inadequate means of cure. The percentage of relapses following the operative treatment, will vary within wide limits according to the technique and experience of each individual operator. Prior to 1889 the results were not what they should have been, owing to faulty technique in the operation itself, and uncertain wound healing. To Bassini, of Padua, belongs the credit of placing the surgical treatment of inguinal and femoral hernia on a sound basis. Following the introduction of his operation in 1889 the results have been much better, and they are steadily improving as the technique is becoming perfected. The operation of Bassini in the hands of surgeons generally has given better results than any other single method. Thus in 1899 from Carle's Clinic, in Italy, there were reported 1,120 cases of hernia operated on by the Bassini method with only 2.16 per cent. relapses. In a report from the Mayo's Clinic, in 1909, (Judd) there were 1,241 cases of inguinal hernia operated by the anatomical operation with 21 relapses (1.7 per cent.). Also 411 cases operated on by the Bassini method with 4 relapses (0.9 per cent.). Bull and Coley, in 1907, report 1,185 inguinal hernias operated on by the Bassini method with only 6 relapses (0.5 per cent.). They also operated on 125 femoral hernias with not a single relapse. Coley (Keene's Surgery) places the operative mortality in non-strangulated cases, including the three common forms of abdominal hernia at 0.5 per cent., and the percentage of permanent cures at upward of 95 per cent. In 1890 the mortality from operation in non-strangulated hernia in four of the largest hospitals of London was 6 per cent. Pott's statistics (Germany) published in 1903, show that the mortality was reduced from 1.9 per cent. prior to 1894, to 0.7 per cent. since 1895. Femoral hernia 0.5 per cent. and ventral hernia 1.1 per cent. A study of 129 fatal cases in which the cause of death was stated, shows that 40 per cent. were due to sepsis, and 30.9 per cent. were due to acute lung complications, both being preventable causes.

Compare these figures with those occurring in the presence of strangulation and note the high increase. In strangulated

hernia Coley places the mortality at 10 per cent. in those operated on within the first 24 hours, thence up to 50 per cent. in those operated on upwards to 72 hours. It is higher in femoral and highest in umbilical.

#### CONCLUSIONS.

1. An individual possessing an abdominal hernia is in constant danger of complications that may readily prove fatal. Hence the necessity of immediate cure.

2. Nearly all inguinal and femoral hernias are due to a pre-formed peritoneal pouch, and are therefore congenital in origin.

3. The surest cure is the modern surgical operation done under the most favorable local conditions, viz: as soon after the appearance of the hernia as possible.

4. The operation is safe, mortality rate 0.5 per cent.; and certain, relapses 0.5 per cent. to 1.7 per cent.

5. As complications appear the mortality rises, and relapses are more frequent.

6. Operation is contra indicated in:—

(a) Children under the age of four years.

(b) The very aged unless there is danger of strangulation.

(c) Very large irreducible hernias.

(d) Bad surgical risks.

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#### THE DIAGNOSIS AND TREATMENT OF CHRONIC BRONCHITIS.

BY

WILLIAM RENDELL WILLIAMS, M. D., PHILADELPHIA.

(Read before the Homoeopathic Medical Society of the County of Philadelphia.)

OF the common complaints that claim our attention at this season of the year, chronic bronchitis, or bronchial catarrh, is the one which presents the least difficulty in actual diagnosis, and possibly the greatest test of our therapeutic resources.

It is a condition met with most frequently in elderly people, but is not uncommon in middle life and even in youth. It may be paradoxical to say that chronic bronchitis is easy to diagnose, and at the same time presents some of the greatest diagnostic difficulties. This is so because it is, perhaps more than any



other lung affection, a condition secondary, and consequent to some other deeper, and oftentimes obscure, systemic derangement. Our diagnosis is not completed until this underlying dyscrasia is thoroughly understood, as will be developed later.

Let us consider briefly the symptoms and signs of this condition. Your case history will develop the fact that the patient has been subject to a chronic cough, usually present during the winter months year after year, and almost, or completely disappearing during the warmer months. Many cases cannot be traced to a primary acute attack, but are insidious in onset and development. Many date their condition from an attack of grippe or other infection involving the mucous membranes of the respiratory tract, or ascribe it to exposure to the fumes of irritating vapors, as formaldehyde in laboratory workers, or to dust, as in the wood, metal or stone workers.

The principal symptoms complained of are cough, with expectoration of mucopurulent sputum, and usually some dyspnoea on exertion, the latter symptom, however, being dependent upon the emphysema, which sooner or later develops in the presence of a chronic cough.

The cough is at first most troublesome in the early morning. Who has not heard that prolonged, racking, gagging cough of an old, gouty cardiopath, for instance, that arouses the household, and possibly the neighborhood, in the early hours of the morning; that seems, if continued, will surely terminate in a ruptured blood vessel; which only ceases when the patient relieves himself of a mouthful of stringy, viscid or perhaps frothy expectoration, leaving the poor victim breathless and exhausted? He may remain practically undisturbed for the remainder of the day, but with the progress of his disease his hours of comfort become less and less, particularly if the weather be damp and cold. As a consequence of intercurrent and more acute attacks the patient's strength and vitality slowly decrease, and the fatal issue is finally determined by the undernourished and overtaxed heart giving up its struggle to maintain the circulation against the increasing pulmonary obstruction.

The character of the sputum may determine the amount of cough. When it is tough and viscid the cough is most distressing. When more liquid the cough is lessened. In typical cases the sputum is made up of mucous and pus mixed uniformly perhaps, or the pus may be observed floating in separate coin-

like masses—"nummular sputum." When bronchial dilatation (bronchiectasis) is present the sputum may be very profuse, occasionally fetid, or offensive from retention and consequent putrefactive changes. In the older patients as the secretion increases the sleep may be disturbed with attacks of dyspnoea, closely resembling attacks of true asthma, or actual bronchial asthma may be an accompanying feature in the middle aged of neurotic tendencies.

The physical signs presented are first, the modification of the breath sounds due to the bronchial catarrh, rales—bubbling, sticky, squeaking, creaking, crackling, groaning, sonorous and sibilant—according to the amount and consistency of the secretion and the size of the bronchials involved. Second, the evidences of emphysema as shown by the shape of the chest, its tendency to the "barrel shape," characterized by the increased anteroposterior diameter, the short neck, high shoulders, blunt costo-sternal angle, and state of "perpetual inspiration;" the dull tympanitic percussion note and evidence of extension of resonance beyond the normal pulmonary limits. On auscultation we find the long drawn out, low pitched expiration, accompanied by the rales referred to.

Let us now consider the average case as it presents itself in an elderly person. Here the chronic bronchitis is simply part of a vicious circle. We find in addition to the signs of bronchitis and emphysema already alluded to, an individual with a moderate or high grade of arterial sclerosis and with an insufficient heart, due to actual sclerotic degeneration of the myocardium or mitral valvular disease, usually both. A heart made incompetent primarily by its intrinsic defects, and secondly by the increasing demands made upon it by the emphysema and the oft repeated pounding from the cough. Such a heart permits back pressure, and consequent stasis in the pulmonary vessels, inducing a condition of passive congestion of the bronchial mucosa which in turn offers a fertile field and an increased susceptibility to infection and catarrhal exudate. Here we have our vicious circle completed. The incompetent heart induces and favors the bronchial congestion and catarrh, which incites coughing, which produces emphysema, which in turn embarrass the heart by their obstruction to the pulmonary circulation.

Going further our subject is possibly accustomed to his daily potion. Alcohol you know, is a very active factor in the causation or at least in the aggravation of a chronic bronchitis. Or

our patient may be frankly gouty, and fond of the good things of the table, in which he is prone to overindulge. His kidneys show evidence of sclerotic invasion, or even interstitial nephritis, and he is in all likelihood constipated.

This brings up a second great factor in the etiology and maintenance of a chronic bronchitis—faulty elimination. The body does not hesitate when it finds its ordinary avenues of excretion (the bowels, kidney and skin) insufficient and unable to carry away its normal waste products, to throw them out through the mucous membranes. When its normal waste, that due to metabolism, is greatly increased by faulty diet, constipation and impaired kidney elimination, an outlet must be found somewhere, and the bronchial mucous membranes are bound to suffer.

When such conditions are appreciated, treatment in this class of cases proves a simple matter. Constipation must be corrected, preferably with the saline laxatives, preceded occasionally by a small divided dose of calomel. The work of the kidneys will be aided and stimulated by increasing the fluid intake with as large a quantity of distilled or alkaline waters as the condition of the heart and blood vessels will warrant, thus diluting and rendering the urinary contents less irritating to the kidney.

The skin should be kept active by warm baths and friction and lastly, and of paramount importance, the diet should be so ordered as to provide for the least amount of proteid waste. This means that all food, no matter how nutritious, in excess of the needs of the individual, should be cut off, for all the excess is waste, and imposes additional and unnecessary work upon the organs of elimination. Explicit detail in regard to diet will be necessary. A daily dietary should be provided with a caloric value just sufficient for the needs of the individual under consideration. The proteid content should be made up from eggs, if they are well borne, fish, fowl and meat. Of the meats it is well to avoid those with a high purin content, such as young meats, as lamb, veal and pork; the glandular meats,—kidney, liver and sweetbreads. Thus confining our selection to beef and mutton particularly, a small amount of bacon (occasionally), fish and fowl. Green vegetables should be selected and the heavy, starchy, underground vegetables avoided. Coffee, alcohol, condiments, fancy made dishes, and foods prepared with grease should be avoided so far as possible. Fats are especially valuable in the form of butter, cream, olive oil and oc-



asionally cod liver oil. They furnish caloric values without demanding too much of the digestion, or increasing the waste. I usually advise specifically a breakfast made up of a well cooked cereal, (oatmeal, cream of wheat or one of the malted wheat foods) with cream and sugar, because I have found this one of the best means of correcting the constipation usually present. It furnishes the hay with the fodder, the waste so necessary to form a soft bowel movement and do its part as a vehicle in carrying off the waste matters thrown out through the intestinal mucosa.

I lay so much stress on faulty elimination, or as it is less correctly termed, auto intoxication, because I am persuaded that it is one of the commonest factors in perpetuating a chronic bronchitis and because it is a phase of the condition which not being readily curable by a bottle of pills, is apt to be neglected by the busy practitioner; but once gone into thoroughly and its importance sufficiently impressed upon the patient in order to secure his co-operation, it will almost surely bring results.

There is another class of cases in which the exciting cause lies in the upper air passages. Children and young people should be carefully examined for adenoids, enlarged tonsils and other nasal conditions which tend to induce mouth breathing. I have been impressed with a number of middle aged persons that have come under my care for chronic bronchitis, usually associated with emphysema and asthma, in which examination of the nasal passages disclosed a polypus or polypi. This has occurred too frequently to be a mere coincidence. Whether they produce their ill effects merely by causing mouth breathing, or through some reflex irritation, I am not prepared to say, but I am certain of the improvement in the pulmonary condition which usually follows removal.

Your detailed attention to treatment will consider the necessity for appropriate clothing; a subject upon which much can be said. Avoidance of cold and dampness by oversight of your patient's residence or occupation, must be considered. Removal to a warm, dry climate for the winter months may succeed in breaking up the condition; many get relief in the pine regions in Jersey. Atmospheric dryness seems to be the prime consideration in advising a change; moderate altitude is not objectionable when emphysema is not marked and the state of the circulatory and nervous systems does not contra-indicate. Appropriate gymnastics are frequently of service; here our aim is

to promote and aid expiratory effort; to secure the maximum emptying of the lungs. These exercises are indicated by the complicating emphysema. In short it is as in most every therapeutic problem, attention to detail which brings results.

Having instituted the foregoing measures, it will then be time to consider our medicinal resources. Possibly and very probably the heart will be the better for a little specific medication. If badly decompensated, rest more or less absolute may be temporarily necessary. A course of brine or carbonated baths will do wonders occasionally and, as I have just said, a little specific medication, such as digitalis, if we have its special indications. Strychnia, one of the best of the respiratory stimulants may answer a two-fold purpose, or one of the nutritional remedies such as arsenic iodide or chloride of gold may be of valuable service. Strophanthus may be preferred to digitalis because of the latter's supposed tendency to raise blood pressure, but in my experience strophanthus will not do anything that digitalis will not do, and do better. Frequently heart medication proves the most valuable means of correcting or modifying the bronchial condition by its direct effect in improving the pulmonary circulation.

Of course medical treatment varies according to the constitutional condition, the nature of the complication, the character of the cough and of the sputum, but it is doubtful if medicine alone will ever effect a cure.

For the bronchial catarrh the most frequently valuable remedies in my hands have proven to be kali bich., ipecac, antimonium tart., arsenic iodide, stannum, stannum iodide, senega and antimonium iodide, all prescribed on their well known symptomatic indications. In addition to the above the iodides in the form of sodium or potassium iodide are valuable when the secretion is viscid and there is an underlying sclerotic or syphilitic basis. And by the way, syphilis is not an unusual cause of chronic bronchitis and bronchial narrowing, and even obliteration, and bronchiectasis. But pulmonary syphilis is a very difficult condition to diagnose.

I have used with much satisfaction in cases where the medium and smaller bronchial tubes are especially involved, with profuse expectoration, terebene, on discs or pellets, or dropped on sugar. Creosote is indicated where the sputum is purulent and profuse. Not necessarily in massive doses by any means, as I have seen good results from the 3x.

Another class of cases which I would like to refer to are those due to specific infections such as the tubercle bacillus, influenza or the pneumococcus. The tubercular cases diagnosed by the sputum and tendency to fever, will be best treated along the well established lines—fresh air, careful nutrition and tuberculin subcutaneously, in addition to the indicated remedy. In the presence of profuse expectoration, creosote is particularly advisable in this class of cases. An inhalation, from a suitable inhaler, of a mixture of beechwood creosote, chloroform, eucalyptus and alcohol—will do wonders to render a far advanced case comfortable. The inhaler to be used for one hour several times daily, 20 drops on the sponge every 20 minutes. It has a wonderful effect in soothing the cough and lessening the expectoration.

Those cases due to a chronic influenzal infection are hard to handle and our efforts should be directed towards making the soil unfavorable to the infection.

Cases of chronic bronchitis due to the pneumococcus are, I am persuaded, not uncommon. In this connection I would like to refer to a case of chronic pneumonic infection in a lad now 13 years of age who has suffered from a chronic bronchitis, and supposed tuberculosis, from his infancy. He has had ten distinct attacks of lobar pneumonia in the last five years. No amount of attention to environment, diet, habits, or medicine seems successful in preventing these attacks. As a last resort I had Dr. Sappington make an autogenous vaccine by culturing the pneumococci, which could always be found in great numbers in his bronchial expectoration, and even in a smear taken from his pharynx. This vaccine was administered by Dr. Sappington weekly, over a period of several months, beginning with a dose of 10 million and increasing to 100 million. This treatment not only had a favorable influence on the pneumonia but has almost entirely cleared up the bronchitis. This case will be reported in detail later, when he has gone several years without an attack of pneumonia, or sufficiently long to consider him cured. The point that I simply wish to make now is that we have a promising method of treatment of chronic bronchitis by vaccine therapy.

In closing I would emphasize the necessity of treating the whole patient. The bronchitis is so often a consequent and secondary condition that our results will too often be discouraging if this fact is not kept in mind.



**THE TUBERCULIN TREATMENT OF TUBERCULOSIS.**

BY

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ALL through my twenty-five years of medical practice, I have always tried to do by my patients as I would be done by, and would not use a remedy on them that I would not willingly use on myself. For that reason tuberculin and I were never good friends. During recent years I have lost many patients by refusing to use tuberculin other than in the homœopathic form. I was getting fairly good results with bacillinum when indicated, and if the way of administering crude tuberculin had not changed, neither the loss of a few patients nor anything else would have induced me to accept it as a useful form of treatment.

The fact that I have had, and recovered from tuberculosis myself, has made me no more willing to poke the crude material into my blood, and I have often thought that the physicians who have used crude tuberculin would have used mighty little if it had been their own skin that had to be pricked.

At the present time very little of the crude tuberculin is used at all, and it has come to be used as near homœopathically as is possible, near enough so, that now I feel safe to use it when required and have had some excellent results with it. Every recent old school work on tuberculosis gives it unstinted praise and classes it as the most valued remedy. I have recently been over the reports of a number of the largest sanatoria in the world, including those near here, and they all use it in almost every case. In fact several patients have told me they found it very difficult to escape its use.

While I am a firm believer in homœopathic remedies the experience of so many sanatoria cannot be passed lightly by; yet I think these reports have caused harm perhaps as much as good. For example, a patient came to me last August who had been treated in one of the large towns of this State by a physician who bragged about having nearly fifty tuberculous patients under his care and all were receiving the tuberculin treatment. As it had not agreed with the man who came to me, he was not pleased with it nor with the physician who gave it.

The tuberculin I like best is the "Bacillen Emulsion," which, if used with any care, is safe. It is made from a finely pulver-

ized virulent culture of tuberculin bacilli, and to one part of this is added one hundred parts of distilled water and one hundred parts of glycerine, and this is again run up for the weaker numbers to several more dilutions. Now, I cannot see why this does not come near being a homœopathic potency. One old school work by Klebs does give homœopathy a little credit by saying on page 568, that "Two homœopathic physicians, Jaeger and Burnett, in 1900, advocated the use of the powdered pulmonary tissue and this substance in its varied potencies is found in the homœopathic pharmacies, but a physician in Saranac Lake has tested this preparation and says, 'Nothing in their sugar-coated pills.'" I wonder how he tested these sugar-coated pills to find "nothing" in them? Not clinically, I will guarantee. And if Klebs had been careful in his history he would have found that Hering, Swan and Beegler used a maceration of tuberculous lungs fourteen years anterior to the researches of Koch.

I have found tuberculin to produce the best results in patients without fever and whose general condition is good. Patients with high temperature should rarely be given tuberculin. An evening temperature of 99 degrees or 100 degrees does not contra-indicate it, but if the temperature runs persistently high, little can be expected from tuberculin until active symptoms have passed. I have been most pleased in results with patients who have reached a stand-still stage,—where nothing they could do seemed to finish their recovery.

As tuberculin is only given once or twice a week at most, and sometimes at much longer intervals, we have a chance to use our homœopathic remedies in the interim, not forgetting our fresh air, good food and other aids—and there are cases requiring them all and will then disappoint us.

Of late I have been using tuberculin in homœopathic dilutions by mouth, and while I am unable to say positively that it is better than our bacillinum or tuberculinum, it is a fresher preparation, and using the symptomatology of the former, I have seen some nice results.

Transactions of the Homoeopathic Medical Society  
of the State of Pennsylvania

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BUREAU OF MATERIA MEDICA

WILLIAM H. YEAGER, M. D., Chairman

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THE TREATMENT OF A NEUROTIC PATIENT.

BY

WESTON D. BAYLEY, M. D., PHILADELPHIA, PA.

IN several papers which have been read elsewhere, the writer has discoursed on what he believes to be the real nature and mechanism of the conditions we term neurasthenia and psychasthenia; and would here merely add a definition that these are characterized by a sense of limitation or perversion of some function of the body or faculty of the mind, with an accompanying abnormal introspection concerning the impairment. The condition may develop as a primary affection, often indeed following some apparently inadequate mental or physical shock; or less frequently it may arise secondarily to some definite organic disease. The present discussion will be limited to a consideration of the treatment of this very common affection.

First in importance is the examination of the patient and the diagnosis of the condition. Concerning these there should be no preconceived opinion. The history of the case should be methodically recorded, and this includes a careful search into antecedent conditions from the time of birth to the inception of the disease. Unusual physical impressions made upon the plastic mind of childhood and adolescence and subsequently lost in subconsciousness may have furnished the nexus for the later developing neurosis. The psycho-analytical methods of Freud and others, (to be referred to later) are based upon this possible ætiology. An adequate record of the case then, should be followed by a general physical investigation. As already remarked neurasthenia may be primary or secondary, and there are many neurasthenoid states which are symptomatic of defi-



nite organic disease. Even if none is found, the somatic condition of the patient may be so deplorably bad as to constitute a predisposition. A thorough and searching physical examination must then, be preliminary to all treatment.

The second consideration in the successful management of these cases is the attitude of the physician himself towards this type of illness. It is the fashion with many (and among them some who pose as neurologists) to regard neurasthenia and other psychoses as a sort of joke, and to refer to these patients as cranks, or still worse, regard them as imposters. I want to assert that neurasthenia with all its unpleasant features is as legitimate a disease as typhoid fever; and the physician who is so bored by these cases that he cannot regard them as being really ill, starts out in their management with a distinct handicap. The distinguished author of *The Poet at the Breakfast Table* aptly remarked that "there are a good many real miseries in life that we cannot help smiling at, but they are the smiles that make wrinkles and not dimples." We may be impelled to smile at some of the vagaries of the neurasthenic, but must not forget that to the patient they are realities.

The physician must be in kindly but firm control of the situation. These patients as a rule are fidgety people who cannot do much or think much in a consecutive way. They want to be changing and trying all sorts of medication and appliances. They are suggestible to anyone who approaches them with a new remedy, and have credulous eyes for every advertised "cure;" so that a preliminary understanding is often a real time saver. After the record and the examination are completed it is well to say that you are now fully cognizant of the nature and degree of their suffering, and that although you may deem it inadvisable to further discuss their symptoms with them at any length, you propose to give their case active and energetic attention, provided they on their part realize that you are acquainted with the value of all the methods of treatment they are apt to hear about, and that you must be the sole judge of what is necessary for a cure. They must furthermore agree at the outset to follow directions implicitly, to take no other medicine than those prescribed, and to remember that we are dealing with a chronic condition requiring chronic management. To this it may be expedient to add that if they are not willing to accede to these general terms you will decline to take the case.

Some such line of talk often clears the ground for a good be-

ginning and gives the physician a more lasting control of his nervous patient. Gerhardt's saying that "the medicine does not heal the disease, but the physician" (may), is a half truth which should determine the attitude of the doctor, but not permit him to neglect established remedial means.

Third: Organic and nutritional defects may require particular attention apart from anything especially directed to the neurasthenic state. Thus, without entering into an extended discussion of the surgical and mechanical co-relatives of a psychosis, and freely admitting that many a woman can have for instance a perineal laceration with retro-displacement without a vestige of psychasthenia, it is notwithstanding a safe common-sense dictum to regard all such physical defects as at least undesirable, and in this generalization I include every possible source of organic irritation in any part of the body. Would you think a flat foot, or an irritable spur on the nasal septum, contributed to the neurasthenic state? Yet they have been undoubtedly observed to do so. A patient not long since, with a supposedly neurotic chronic diarrhoea was found to have a complete sphincteric laceration from an old perineal tear. Among these mechanical considerations do not forget eye strain and the various conditions of the auditory apparatus. In the investigation for other diseases associated with a supposed neurasthenia, look out especially for latent tuberculosis, the incipient anæmia and renal disease, with the methods appropriate for the discovery of each.

The value of psycho-therapeutics in the general psycho-neuroses is very considerable, but it is difficult of employment because of the time consumed and the environment necessary for its proper application. To attempt to hypnotize a patient in your office with the telephone ringing, restless patients awaiting their turn, and a colleague or two who knock at the rear office door and want to see you "just for a minute," is simply out of the question. For therapeutic hypnotism one must have undisturbed quiet, yet with its proper use in suitable cases I have seen prompt and permanent results.

A more recent and perhaps more promising method for the general practitioner is the "psycho-analytic" procedure of Freud or "catharsis" of Breuer. These are based upon the psychological observation that in a psychoneurosis there is, in addition to the normal complex, co-ordinated mental processes which make up the individual ego, a second and abnormal

group of ideas which date their origin from some unpleasant experience or shock or repressed emotion, which consciousness cannot fully eliminate yet may succeed in so altering that they lose all semblance of their original character. These repressed ideas are ever reappearing in consciousness in some altered or symbolic form and are not resolved into the normal stream. There is much more to be said about these "foreign bodies" so as to speak in a field of consciousness, and the endless turmoil that arises in consequence, but this suffices for our present purpose. The method of treatment based on these principles is to persistently dig into past and forgotten memories by the association of ideas. The patient concentrating his thoughts upon the disturbing symptoms is directed to recount all of the associated ideas that come into his mind relating to them; and he must not withhold anything no matter how trivial, personal, or unpleasant it may be. This procedure, adroitly encouraged, will gradually reveal forgotten impressions connected with the inception of the morbidities, and as they are rehearsed and brought into critical conscious observation, the consciousness of the patient appears to be able to shake itself free of them.

What may be called methodical diversion is another very important aid in the treatment of the psycho-neuroses. A person with several well balanced avocations seldom becomes neurasthenic. It is the limited routine, usually of business life that favors neurasthenia, cutting in the nervous system a little narrow groove, figuratively speaking, which represents the patient's daily routine activities. To develop the energies of a totally new set of brain cells is the surest way of resting these much used and irritable ones. Hence, to launch the patient into lines of work which are totally variant from his usual occupation is a very useful proceeding. I have had such patients, for instance, take regular courses under skilled teachers, in botany, art, literature, music, mechanical trades and similar employments; at times compelling them when they thought they could not possibly do it, with very satisfactory results.

A so-called rest cure is necessary in many cases, and it has the double advantage of enabling you to employ some form of psychotherapy while you are improving the bodily health. A rest treatment should not be a routine measure, but like every other procedure, requires adapting to the needs of the individual case. If this treatment is to be employed, the physician should attend to every detail of it in order to get the best results. The



selection of the nurse is most important. A patient is no less sensitive and intelligent because she has neurasthenia, and she should not have inflicted on her for weeks at a time some crude, uninspiring ignoramus of a nurse. Again it is folly to undertake such treatment in the average general hospital where the clanging of the ambulance bell, the smell of ether, and the moaning of the operated patient in the room adjoining are sources of disturbing alarm; not to mention the impossibility of securing in a hospital the proper diet necessary for hyper-feeding. Personally I have several smaller places out of town, where all of the details essential for properly conducting the rest cure are under my own control.

The medical treatment of these cases is of considerable importance. It has been said that in a neurasthenic the symptoms are so variable that the search for the homœopathically indicated remedy is an endless and ever changing task. I have not found it so. While the patient's notions may drift a good deal, yet there are certain underlying symptoms which are permanent and which afford a rational basis for selection. With the anamnesis of each case I am apt to go with confidence to the repertory and the materia medica, and I wish to here state that I am entirely opposed to the use of physiological hypnotics, opiates and other dopes in the treatment of neurasthenia; they are harmful and unnecessary.

Our provings are so rich in mental phenomena that it is difficult to attempt a generalization of the drugs to be employed. The remedies here to be mentioned by no means mark the limits of choice; all that can be said of them is that they are the ones more commonly useful. At the outset I must confess to a few empiricisms, for instance in the badly nourished cases, perhaps under rest treatment and where no particular drug seems indicated, I am apt to give in capsules a freshly made trituration of iodide of arsenic gr. 1-100 alone or combined with 1-2 grain of iodide of calcium. This is best indicated when the primary condition is somatic and the neurasthenic phenomena appear to develop in consequence of it. When these two factors are reversed, that is where continued or repeated troubles or worryment have sapped the nervous vitality and nutrition is impaired as a consequence, *ignatia* tincture in material doses is to be preferred. It is superior to either *nux vomica* or *strychnia* which are in more common use. The third empiricism to which I plead guilty is in the use of *scutellaria*. In nervous, restless,

sleepless, fidgety cases undergoing a rest cure, especially where there is a history of overstimulation by coffee, drugs or alcohol, the skull cap in tincture or infusion of the dried plant, has been very serviceable. Credit for the use of this is due to our friends the eclectics.

To give the indications for the following remedies would involve the process, here inexpedient, of copying symptoms from the materia medica which is equally accessible to all of us, besides prolonging this presentation to inexcusable length. Each has its individuality, and like the separate tools in a carpenter's kit, each has its special functions and sphere of usefulness. One faulty habit we are too apt to fall into is the mental association of a drug with its main characteristic, ignoring its collaterals. Perhaps I make this statement clearer by an example. Take for instance, aloes. At once we think of a diarrhœa with certain characteristics, and likely that is all. Yet a closer study of aloes shows it to have important and interesting mental and other symptoms which give it a specific value other than that suggested by its main effects.

*Agaricus*.—Paraphasia, spinal hyperasthenia, tremors and fibrillations, hypersensitive to cold air. Ocular neurasthenia (also cactus and ruta).

*Agnus castus*.—Forget the "old sinner" business—it has other indications.

*Ailanthus*.—Muddled by mental effort, confused by figures, exhaustion and inertia.

*Aloe*.—Any mental labor fatigues; hates and repels people; a vertigo makes everything seem insecure.

*Alumina*.—Confused identity, paraphasic, fears lunacy, dreads death yet thinks of suicide. Mood now confident, now timid. Worse in the morning on awakening. Pruritus on retiring.

*Ambra*.—Slow of comprehension, memory confused and impaired. Sad, despairing and fears insanity. Rich in neurasthenic symptoms and frequently indicated.

*Ammon. carb*, *Aesculus*, *Anacardium*, *Ant. crud*.

*Arg. nitr*.—Memory confused, sensory aphasia, cannot do his work—many other important indications.

*Bovista*, *Calc. carb.*, *Carbo veg.*, *Causticum*, *China*.

*Cocculus*.—Mopes on one unpleasant subject, absent-minded,

vacillating. This remedy has the peculiar occipital aching so common in neurasthenics (see also *Prunus Spinosa*, *Zinc met.* *Stront carb.* and of course other remedies).

*Coffea*.—"Sleepless from over excitement of body or mind."

*Gelsem*, *Graphites*, *Hclonias*, *Ignatia*.

*Lachesis*.—Restless sleep, awakens much agitated and must then talk about his complaints.

*Lillium tig.*—Morbid fears of various kinds, vertigo when walking, fulness in head as from internal pressure. Important drug, and deserves close study.

*Lycopod.*—Mag. carb. (insomnia after 2 P. M.); *Manganum acet.* (pains in neck and back); *Mercurius*, *Natr. mur.*

*Nux vom.*—Fidgety business men who are worse in the morning and after meals. (Study it in conjunction with *Arg. nitr.*) Hyperasthetic high tempered and easily offended. Sleeps in early evening, sleepless at night, or awakens at 3 A. M.

*Oxalic Acid.*—Hyperchlorhydric cases with anginoid symptoms.

*Petroleum.*—Occipital headache and discomfort, mental effort results in stupidity, spinal pains, gastric symptoms.

*Pulsatilla.*—Aversion to fats, poor sleep in early night; uneasiness and vague fears in the evening.

*Phosph.*

*Phosph. Acid.*—Sexual neurasthenia, numbness and weakness in legs, stumbles easily, drowsiness, headache from behind forward, better from reclining.

*Plumbum.*—Heaviness of head, especially in cerebellum, pseudo-appendicitis.

*Psorinum.*—Sleepless after midnight, dwells on one idea which he cannot get rid of—many other suggestive symptoms.

*Rhus tox.*

*Sabadilla.*—Headache from mental overwork; postnasal catarrhal conditions, sexual neurasthenia with weakness of legs. Gastro-intestinal or abdominal neurasthenia.

*Salix nigra.*—In the fluid extract—empirically for sexual neurasthenia with weak, draggy pain in the back.

*Sanguinaria.*—Hyperchlorhydric cases. Occipital headache going forward into the right brow. Sleepless or has active dreams and awakens frightened.

*Sepia.*—Weak memory and impaired mental activity from overwork. Basilar headache, very sensitive to odors (of cook-



ing Colchicum), sexual weakness and genital sweat, palpitation of heart from emotions. Is easily tired, and sleepy by day. Cannot sleep after 3 A. M.

*Silica*.—Mental effort causes fatigue and confusion of mind. Headache worse from effort, and relieved by warmth and quiet. Stiffness and pain in the back, sweat of hands, feet and axilla. All of the limbs, particularly the hands, tremble; sleepy but cannot sleep.

*Spigelia*.—Cannot work, occipital distress, gets headache from thinking. Fear of sharp pointed instruments. He is better after eating. (Hyperchlorhydria?) Cardiac neurasthenia.

*Selenium*.—General symptoms of sexual neurasthenia. Longing for alcoholic stimulation. Very forgetful, especially in business; confused speech.

*Stannum*.—Cannot get rid of a fixed idea. Very forgetful. Morning headache over one eye, extending over entire forehead—often with vomiting. Extremely nervous and perhaps suicidal.

*Staphisagria*.—Hypochondriacal, feelings easily hurt, dull feeling in the head with inability to perform any mental labor. Sexual neurasthenia.

*Ratania*.—Gloomy and irascible, great general weakness; rectal symptoms.

*Veratrum Alb.*—Worse in morning in bed when he broods over all kinds of troubles. It is likely that we often prescribe Nux vom. when Verat. is the remedy.

*Zincum met.*—Fidgety feet, cannot keep them quiet; trembling in limbs; twitchings in muscles. Face very pale; mental depression and weakness of memory.

#### DISCUSSION.

DR. YEAGER: Personally, I have found phosphorus to be a valuable drug in the treatment of neurasthenia. It seems to me that phosphorus is to the tired, worn out nerves, what arsenic is to the over-worked and bruised muscles, or what iron is to the depleted blood, or what rhus is to the abused connective tissue.

DR. SEIP: A man never suffered from neurasthenia more than I did. And I want to tell you how I got it. Some years ago my preceptor wanted me to make a proving. I took macrotin in the 3x trituration; later I took the 6x. It produced a great many nervous symptoms and it took me years to get rid

of them. *Argentum Nitricum* is one of the best remedies in neurasthenia.

Other important remedies mentioned by the doctor were *scutellaria* and *ignatia*. Personally, I prefer *ignatia*.

DR. GAY: I am inclined to believe that a few years ago neurasthenia was not properly understood. In many instances the neurasthenia patients were supposed to have some disorder of the stomach, kidneys, heart or almost any other organ. I would like to emphasize what Dr. Bailey said about the analysis of these cases by inquiring into old memories which have been largely forgotten. For example: Neurasthenic conditions may arise from a fright or a death in the family or some other psychic experience that happened years ago. It used to be thought that neurasthenia was a disease of the rich, but I have found it among persons in all walks of life who are undergoing persistent or long-continued strain.

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#### DILUTIONS OR POTENCIES, WITH SUGGESTIONS FOR USE.

BY

EDWARD CRANCH, M. D., ERIE, PA.

As no less an authority than the Hering Medical College, of Chicago, has warned us in its "motto," that "There is no law of potency, but there is a law of cure," it would be premature to attempt the exposition now of any sure law of potency, yet there is no harm in making some tentative study in that direction. These remarks must necessarily be brief, and will, it is hoped, lead to fruitful discussion.

This is the sum of the thesis of the present paper, disorders that are strictly functional, exhibiting no pathological change greater than obtains in the different forms of obstructive disease, where the simple restoration of free absorption, secretion, and elimination is all that is needed to restore health, such functional disorders are best met by the higher dilutions or potencies, while disorders attended with serious structural change, as in syphilis, tuberculosis, and cancer, are better met by the lower scale of dilutions or even by the crude drug, always following the homœopathic indications.

A series of experiments of the utmost interest and value has been conducted in France by P. Jousset, as recorded in *L'Art Medical*, and in the *North American Journal of Homœopathy*, in May, 1909.

By these experiments, showing the effects of varying dilutions upon the growth of *aspergillus niger*, it is well established that, after the actual death of the plant, caused by the crude drug, the most positive effects in the retardation of growth was produced by the action of the sixth dilution, and while there was marked positive action even up to the fiftieth dilution, which was the highest potency experimented upon, there was little or no difference appreciable between the action of the twelfth and any higher scale.

This agrees with Dr. Charles Mohr, who, using for some years the two hundredth, then for some years the thirtieth, then for some years the sixth, was unable to decide in which series he had the best results.

Given cases, failing to respond to one potency, often do respond when the dose is increased or diminished, but the sum of the present writer's experience has been in the direction of the thesis stated at the beginning of this paper, namely, that when the disease is limited to obstruction of function, the smaller dose, or higher potency, is generally better, but that when an actual structural change, as in syphilis or cancer, is to be attacked, the high potencies only irritate, while cure, if at all possible, must come from the action of the lower or cruder dilutions or drugs.

As for the very high attenuations, (above the ten thousandth, say), they do not appear to be actually as high as they are often labelled. We must not forget the remark once made by Dr. Swan, who put up fluxion potencies to the cm, cmm, mm, dm, etc., that his method *must* be good, because sometimes he could, in these highest potencies, detect some of the color of the original drug! No wonder they were efficacious, when their actual potency was thus demonstrated to be of the same as the second dilution!

So the present writer has dismissed all thought of "fluxion" potencies, and confines himself to potencies made on the regular Hahnemannian scale, considering the two hundredth high enough for the most dangerous drugs, such as the serums or the snake poisons, which have been found risky to some patients when given in the thirtieth or lower, while for the great majority of drugs, the twelfth or thirtieth is to be regarded as the highest needed, and in some drugs, and some diseases, the first, second, or third is best.



**THE METHOD FOR THE SELECTION OF THE INDICATED HOMOEOPATHIC  
REMEDY IN DISEASES OF INFANCY: WITH SOME  
CLINICAL RESULTS.**

BY

WILLIAM B. GRIGGS, M. D., PHILADELPHIA.

THE so often asked question, "How do you successfully prescribe for infants who are unable to talk; and what results are obtained from the indicated homœopathic remedy?" has been the only excuse for offering this meagre paper; and as this paper has wholly to do with the simple inductive method of homœopathic therapeutics, I shall not consider any adjuvant measures.

In no department of medicine will the physician's skill and judgment be so taxed and his powers of observation so accurately brought to bear as in diagnosing the proper therapeutic remedy in diseases of infancy and childhood.

The infant has no speech save its cry of hunger or of pain, and therefore we must rely chiefly on objective symptoms or signs, and to the trained observer there is generally a rich store laid bare. Subjective symptoms being impossible, so far as the patient is concerned, the history of the case is also usually worthless unless we have to deal with a fairly observant mother or a trained nurse.

The true law or method of selecting a remedy for the sick patient is thoroughly expounded in the principles laid down by Hahnemann, but few of us thoroughly perceive them, and without strict adherence to this method I am sure we cannot hope to have the brilliant results we expect in our prescribing for sick infants.

To get a perfect result we must have the exactly similar remedy. In homœopathy medicines can never replace each other nor can one be as good as another. There is no doctrine of substitution in homœopathy; and with these few precepts of the law in our memory we shall see how foolish it is to make snapshot prescriptions, to prescribe on one symptom, or simply to attempt like the book-worm symptom hunter to diagnose a remedy from a batch of garbled symptoms.

The prescriber must get the genius of his drug and of his case, as I shall illustrate with a few bonafide instances from my clinical practice.

Probably one of the first things to be done is to remove the cause if possible. If it is of a nature to be removed by physical means do it, if it is pathogenic and belongs to the sphere of drug action, give the indicated remedy and watch it disappear. I will quote a case showing, first, my error in not seeking the true cause, and second, the result when that cause was finally found.

About a month ago I had the following case in the isolation building at the Children's Homœopathic Hospital of Philadelphia: Female child, about two years old, was admitted to the hospital for some ear trouble.

Being exposed to some contagion, she was removed to the isolation building apparently convalescent. In a few days she developed fever and diarrhœa which, while temporarily relieved, came on regularly in attacks about twice a week and got worse. I prescribed a very careful diet and remedy until the child emaciated and was getting almost beyond my help. The case now assumed this serious aspect. Child feverish, worse at night, redness of cheeks, sleeplessness, yawning, sobbing, fretting, no appetite. Stools frequent, mucous, slimy blood with mucous, greenish frothy, expelled with violence, complained of pain in stomach, no indication of tenesmus and the nurse remarked that if the mother could be made to stay away the child would not get this fever and restlessness. I did not know the mother was visiting, and I immediately prescribed Capsicum (30), with the result that the nervous condition was immediately improved, stools became normal, the child was discharged cured in a short time and the mother also continued her visits with no ill effect. The homesick condition was evidently removed by the capsicum.

Hahnemann says: "The examination of a particular case of disease, with the intent of presenting it in its formal state and individuality only demands on the part of the physician an unprejudiced mind, sound understanding and attention in observing and tracing the image of the disease." (Also *Organon*, paragraph 84), "The patient details his suffering, the persons who are about him relate what he has complained of, how he has behaved himself, and all that they have remarked in him. The physician sees, hears, and observes with his other senses whatever there is changed or extraordinary in the patient." This means a careful methodical diagnosis in Hahnemann's language. The examination must be continued with due respect

to the nature of the sickness and with due respect to the nature of the *materia medica*. Some symptoms have reference to pathology and diagnosis, while others have reference only to the *materia medica*. The symptoms must therefore be constantly weighed in the mind.

To get the totality for an accurately diagnosed remedy, moreover we should have the family history recited, the previous history of the patient, including previous illnesses; when at once we think of remedies whose role is in the place where conditions are constantly relapsing, and children who are born of constitutionally diseased parentage can but assume the type of the *pabulum* of which they are an integral part.

The constitutional remedy often depends on this fact, when the diathesis will also present itself, suggesting, perhaps, the various antipsoric remedies, such as *baryta carb.*, *calc. carb.*, *calc. phos.*, *phos.*, *silica*, or *sulphur*, if rickets exist. Or, *acetic acid*, *arsen. iod.*, *calc. carb.*, *calc. phos.*, *iodine*, *lycopodium*, *nat. mur.*, *phosphorus*, *silica*, *tuberculinum*, if the tubercular diathesis is prominent.

The syphilitic diathesis will frequently require *asafoetida*, *aurum*, *kali. jod.*, *kreos.*, *mercuries*, *nitric acid*, *syphilinum*.

Scrofulosis, with its eruptions and enlarged glands, makes us think of *baryta carb.*, *baryta jod.*, *calc. ost.*, *calc. phos.*, *ferrum*, *graphites*, *hep. sulph.*, *iodine*, *merc. sol.*, *sulphur*, *theridion*, etc.

These remedies are mainly suggestive, they all present in their pathogenesis pictures of these various conditions, but must be differentiated and used only when the totality of symptoms agree.

Now, having noted the diathesis, if any, we will inspect the skin, whether dry or moist, hot or cold, or cyanotic or developing some particular rash or skin eruption with its peculiar lesions. An abrupt onset of fever with dry skin will lead us to *aconite*; or, if occurring during some severe acute infectious disease or chronic ailment to *apis*, *arsen. alb.*, *muratic acid*, *nux. mos.*, *phos.*, *rhux. tox.*, *sulphur*, etc.

Hot, moist skin suggests *belladonna*, *chamomilla*, *opium*, etc.

Cold skins require *calcarea*, *cuprum*, *camphor*, *digitalis*, *secale*, *veratrum alb.*, etc.

Cyanosis may require *arsenic*, *digitalis*, *hydrocyanic acid*, *tart. emetic*.

The location of sweat is all important, we are all well acquainted with the head sweats of *calc.*, *ost.*, *calc. phos.*, *cham-*



omilla, merc. vivus., sanicula, silica, or verat. alb., or the peculiar modality of sambucus. The head and face hot and dry during sleep, breaking out into a profuse perspiration as the child awakens; or, as I have often verified under thuja, sweat on all covered parts except the head, which was hot and dry.

As for skin diseases, with their eruptions, which are peculiar and characteristic to themselves, the indicated remedy must be based on the patient himself.

Swellings must be thoroughly examined and their cause discovered, whether it be rheumatic, tubercular, inflammatory or dropsical. I well remember prescribing for a case of dropsy in a very pale, anæmic child without much benefit until I found the child was depleted by severe nasal hemorrhages; china promptly removed this dropsy and the child improved to ultimate recovery. "Hahnemann says seek the cause."

The interpretation of the various cries are solely the result of experience and constant observation, likewise the prescription.

The shrieks of meningeal irritation lead us to examine such remedies as apis, bell., hellebore, sulphur, tuberculinum. When the symptoms agree.

Painful dentition and the pains of otitis can be promptly relieved by the indicated remedy. I have seen these severe pains promptly mitigated and further trouble aborted by the remedy carefully selected on the general symptoms and the modalities in the case.

Prescribing for diseases of the nervous system demands the most careful analysis of the symptoms; all the signs and reactions must be thoroughly elicited and differentiated. A scientific homœopathic prescription for a severe case of meningitis always needs an examination of the whole patient, including the urine and the spinal fluid; and as the "mind makes the man," according to quotations from the Organon, the mental symptoms demand very careful consideration.

A careful physical examination of the chest may reveal to the prescriber the rales or consolidations, fluids or exudates in the cavities, a tumultuous heart beat or valvular murmurs; the presence of endo and pericarditis, which are all part of the totality and must be given their relative symptom value.

The negligence of a thorough physical examination with inability to recognize physical signs, to make the necessary clinical tests and to interpret their scientific meaning is one of the fundamental causes for the dismal failures made in prescribing

for young infants. In no other way, to my mind, can the true totality of symptoms and signs be reached.

I grant that there are some cases of infant illness which present very few symptoms, even after a close clinical examination. Here we must follow the law and wait, or if imperative prescribe on the last named symptoms that have occurred; those that are peculiar to the patient, and if the symptoms disappear in the reversed order of which they appeared, we may be sure we have selected a good remedy.

The gastro enteric tract demands very careful attention and the discussion of this alone would make quite a voluminous paper. Forty per cent. of all the ailments of young infants find their origin in some gastro enteric disorder which, of course, is excited by bad hygiene, improper or contaminated food, hot weather, humidity, and even disordered dentition, etc.

The first prescription for these cases, as a rule, is scientific feeding, combined with proper hygiene. We must just strike at the foundation; then the true morbid state presents itself unmasked; and a methodical examination must be made from mouth to anus, including thirst, appetite, vomiting, digestion, abdominal pain or distention; stools—their frequency, color, consistency; character—whether watery, fecal, mucous, slimy, or bloody, together with all the concomitants of these conditions; such is the tedious road for the careful homœopathic prescriber, but its results repay for the time and care entailed therein. Having now a working basis for the method of homœopathic prescribing, I will briefly review a case showing the necessity for careful observation in the homœopathic treatment of a serious case of illness.

Master John K. Age, 8 months. In Philadelphia. July 2, 1910. Family history, good. Previous history, good. Birth, natural. Environment, fair, being the fourth living child. No teeth. Diet, condensed milk since sixth month. Present illness began almost 24 hours before I saw the case.

Present symptoms, July 3, 5 P. M.—Weak child, vomiting all diet, clean tongue, some thirst, six grass green mucous stools, some froth, temp., 102: R̄ barley water and plain water only, and ipecac frequently repeated. Assured the mother child would promptly recover. July 4, 6 A. M. Called in great haste by phone, baby has had bad night and was sinking, and to my surprise there was a most serious change in the last 12 hours. It vomited everything forcibly as soon as it reached the

stomach; rapid emaciation, eyes sunken, skin cold, very restless, whining, whimpering, colicky pains, dark green, frequent mucous and watery stinking stools. I prescribed arsenicum alb. 30; diet, whey, boiled water, and champagne in teaspoonful doses. Baby was ordered to suburbs and taken immediately there by the mother. At 5 P. M. to-day, I received another phone message baby no better, even weaker. Went to see baby immediately, found vomiting the same; I now washed the stomach with sterile water, 100 degrees. Gave panopepton, continued whey and champagne, and did not change the prescription of arsenicum alb. At midnight the anxious father called on me, told me his baby was dying, it was as cold as ice. I gave him camphor for his baby, also ordered heat applied. I was about as disheartened as the father, so went out to see the baby two hours later, and found very little of the original baby of two days before.

The baby had not vomited for three hours after the stomach lavage, but soon again began the same old vomiting. I now had a moribund case to prescribe for.

A rapidly emaciated, shriveled, cold, blue baby, sunken eyes, ice cold extremities, body cold and clammy, the greatest possible exhaustion, restless, feeble, whining. Child seemed stilled by a little water, but immediately vomited it. Stools very small, watery, bloody, olive green in color. Being laid upon some hot water bags the child seemed to whine and try to work itself away, and the mother remarked "that he was better out on the lawn without the blanket around him," that is he was quieter and to her seemed easier. I then stumbled over secale corn. as a dernier resort. This was 4 A. M. I gave a dose and left some to be frequently repeated, thinking now that my trouble was nearing its end and the official certificate was next in order, I went home. I received no word about patient all forenoon, so late in the afternoon I went prepared to pay a call of sympathy, but on my arrival found my patient had slept four hours, had not vomited; also took some champagne and panopepton, but had a few offensive stools. To cut the case short, I will say, in 36 hours I had this baby taking equal parts of skim milk and barley water, and in one week it was taking a normal milk mixture for its age, and it gradually regained its weight, although not as a normal regular gain, but nevertheless it recovered. Secale was the last remedy prescribed and the child is well at the present time, having teethed normally during the present



year. I believe if I had methodically examined this case and noted the modalities, I should have seen the remedy before and thus saved time and suffering.

I believe the incomplete diagnosis of both the case and remedy, of which we are guilty unconsciously in our daily hurry and toil, is solely responsible for the failures we have in our prescribing, and the great lesson we have to learn is that we must use the same methodical care in diagnosing our remedy as we use in diagnosing our disease. It must be thoroughly understood that mechanical and surgical conditions must need immediate mechanical or surgical interference. The importance of attending to these cases early and conscientiously is, I hope, unnecessary to urge here.

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## BUREAU OF SANITARY SCIENCE

G. J. BERLINGHOF, M. D., Chairman

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### MEDICAL INSPECTION OF SCHOOLS.

S. HAMILTON, JR., M. D., PITTSBURGH, PA.

MEDICAL inspection of schools, upon which I have been asked to speak to you, is a subject which has stirred up considerable interest and discussion among both the general public and the profession in this State and, especially in Pittsburgh during the past few months. Of course you all know that medical inspection is not original in Pennsylvania; in fact, it has been in operation in nearly 100 cities and towns in this country outside of Massachusetts, and in that State it is in operation in every city and town. Medical inspection of school children has been in operation in certain European cities for more than 35 years, and in some foreign countries the work is national in its scope. As a matter of fact, America is one of the last of the civilized nations to seriously consider this important problem. Quoting an extract from a memorandum of the British Board of Education: "Medical inspection is founded on a recognition of the close connection which exists between the physical and mental condition of the children and the whole process of education. It seeks to secure ultimately for every child, normal or defective, conditions of life compatible with that full and effective

development of its organic functions, its special senses and its mental powers, which constitute a true education." Systems of inspection in use here in America vary widely in scope and thoroughness.

Medical inspection in Pittsburgh has in view two objects:—

1. Routine class room inspection, which is solely for the detection of communicable diseases, and which relates, primarily, to the immediate protection of the community.

2. The physical examination of each child, which aims to discover defects, diseases and physical condition, thus looking to the securing, and maintaining of the health and vitality of the individual. Physical examinations, to be effective, must follow the child from grade to grade and from year to year. It needs the constant attention of the teacher, with reference to seating the deaf where they can hear best, and those with poor vision where they can see best, as well as the constant co-operation with the parents.

Two great forces have been working in America toward medical inspection of school children. On the one hand is medical science, operating through its Boards of Health in order to protect the community. On the other hand, educational science, operating through the great school systems of the country and aiming at the development and intellectual equipment of the individual. These two movements are being compelled to coalesce on account of certain changes in the constitution of society. In the first place, we are rapidly changing from a rural to an urban nation, over one-third (1-3) of the total population living in cities. This moving of the population toward centers has made it necessary for the communities to pay attention to pure water supply, sewage, street cleaning, problems of light and air in dwellings, isolation of cases of contagious diseases, conditions and hours of labor, and a thousand other matters which in a rural community were of importance to the individual families only. Another thing of great importance is the change that is taking place in our racial stock. This is important because standards of living, of cleanliness and freedom from vermin are being brought in by recent immigrants, which standards are not only different from those that existed under early American conditions, but which are opposed to those higher standards of life that are essential to the individuals in a democracy that is to last. In addition to this, the schools that were in existence years ago were widely

separated, were open only a few months and were attended by a small fraction of the children, and so did not present any special problem from the standpoint of community hygiene. At present, the schools in their intimate mingling of children from practically all families for most of the year, afford by far the most extensive means that exist, for the spread of contagious diseases.

Certain changes have also taken place in the constitution of society, which have involved a re-adjustment of the physiological functions of the individual in his relation to society. This change, which is most important to children, refers to work and play. Man, by harnessing the great powers of nature, has made it unnecessary for the great bulk of the world's work to be done by human muscle. Machinery is taking up the former work of human and animal muscle. The normal work of children, done for the parents about the home, is going. The muscular work, which strengthened the muscles, enlarged the chest and aided in giving power to live, is largely gone. The other great source of muscular exercise and physical development for children is play. This is being attacked from three sources:—

1. Time for play.
2. Space for play.
3. Traditions for play.

School hours and home study take most of the day.

Our cities are being built up without playgrounds.

The great games of the world, which have been handed down from child to child for generations, do not, in the main, suit modern city conditions. These facts, bearing on the alterations of children's lives that are occurring, are back of the movement for physical training, playgrounds, etc., in departments of education. The State provides for the education of all of its citizens as a measure of self-protection. The facts given show that the State must also take notice of their physical welfare for the same reason. Health and education belong hand in hand. Modern science is beginning to teach us that the "cure-all" for the ailments of old age and restoration of the health of youth must be the diligent conservation of that health from childhood, if it is to be enjoyed in after-life. Too often is the physical well-being of the child neglected by the carelessness and thoughtlessness of parents. A mistaken idea that is common is that "all children must have the common children's diseases, and the sooner the better." If Johnny breathes through his mouth they



say, "He always did that, he will outgrow it." Again they say, "He always turns his head to one side when he reads or writes. It's a habit he has got into. He has always been pale, it's nothing unusual."

With the changes in the length of the school term and of school years demanded of the child, has come a great advance in the standards of work required. When the standards were low, the work was not beyond the capacity of even the weaker children. Now, many pupils are unable to keep up with their classes and you hear the terms, "backward," "retarded," and "exceptional" applied to children by school men. Inquiries into the causes underlying the phenomena of "backward" and "retarded" children have been instituted. Surprising numbers of children have been found who, through defective eyesight, have been seriously handicapped in their school work. Many have defective hearing. Many other conditions are found which have a great, and formerly unrecognized influence on the welfare, happiness and mental vigor of the child. Attention has been directed to the real significance of adenoids and enlarged tonsils, of swollen glands and carious teeth. Medical inspection aims at discovering those physical defects which interfere with the child's ability to do his school work or which, if neglected, will seriously affect his physical efficiency in after-life. A child with defective eyesight, placed in a school where physical defects are unrecognized and disregarded, is unable to see distinctly and headache, eyestrain and failure follow all his efforts to study. He cannot see the blackboards and charts without great effort—everything is blurred. Neither he nor his teacher knows what is the matter, but he soon finds it impossible to keep up with his companions, and becoming discouraged, he drops back. In no better plight is the child who is suffering with enlarged tonsils and adenoids, which prevent proper nasal breathing. Perhaps one of his troubles is deafness. He is soon considered stupid and his poor progress in school strengthens this impression. Through no fault of his own he is doomed to failure. He neglects his studies, hates his school and leaves long before he has completed the course. We are beginning to find out that many of our backward pupils are backward purely and simply, because, through physical defects, they are unable to handle the work of the school program. What these defects are, and the causes that lie behind them, are things that we must know and guard against. Education, without

health, is useless and it is better to sacrifice the former than the latter. Children are not dull or defective without some cause.

The objection made that the State has no right to permit or require medical inspection of children in the schools will not bear close scrutiny nor logical analysis. The authority which has the right to compel attendance, and prescribe certain courses of study, at school, has the added duty of insisting that no harm shall come to those who go there. The exercise of the power to enforce school attendance would be dangerous if it were not accompanied by the appreciation of the duty of seeing that the assembling of the pupils brings no physical detriment. Nor is the State, in assuming medical inspection of the pupils in public schools, trespassing upon the domain of private rights and initiative. American systems do not, (like the feeding of school children in France and England), lessen the responsibility of the parent nor tend to weaken, or supersede, the home. Under our medical inspection, absolutely nothing is done for the parent but to tell him of the needs of his child, of which he would otherwise have been in ignorance. It leaves him with a larger responsibility than before of tending to these needs. Whatever view we may take of the right of the State to enforce measures for the correction of defects discovered, the arguments do not enter the present discussion. The important condition confronting us is that the school affords an immense opportunity for detecting, and checking, diseases and defects among children.

I will briefly outline our plan of procedure in Pittsburgh:

The routine class room inspection is done in the morning, and the inspector is required to visit each class in all his schools every other day. On entering the class room the inspector takes his position near a window where he may have the best possible light. At a signal from the teacher, the pupils all rise and file slowly past the inspector, holding their hands in front of them. The inspector scrutinizes each child closely for signs of illness,—as early symptoms of measles, mumps, chickenpox, scarlet fever and diphtheria; for pediculosis, skin diseases, such as ringworm, scabies and impetigo; and for acute conjunctivitis and trachoma. Suspicious cases are drawn out of line and sent to the physician's room for further investigation, together with "old cases" which are still under observation, and children who have returned to school after three or more days' absence, without satisfactory explanation for being away. After further

investigation of these children, if they are found by the inspector to be suffering from any of the conditions which call for action, they may be either excluded for a definite period, or instructed to seek medical attention, without discontinuing school, or if it is an "old case" recovered, the child may be discharged. All cases of sore throat must have cultures taken. Nothing in the way of treatment for these cases is done beyond directing them to consult their family physician, or to go to a dispensary. All cases of disease are recorded on index cards, each room having a separate card, the child's name, disease, date discovered and action taken, being put down. Each day a report of the schools visited, the number of children examined from each school, the number of different diseases found and action taken, together with the names, addresses and causes of exclusion of the children sent out, is sent to the Chief Medical Inspector's office.

Pupils are very apt to attend school during the earlier stages of diphtheria and measles, and during the late but very infectious stage of scarlet fever, thus spreading the disease throughout the community. Medical inspection greatly reduces this danger. In Boston since medical inspection was introduced diphtheria has fallen off two-thirds (2-3) and scarlet fever five-sixths (5-6). That medical inspection has been an important factor is shown by the fact that before the inspection began some diseases, such as diphtheria, for instance, were more common during the school term than during the vacation period, but that after inspection was introduced they were less common during the school term than during vacation. Again, it is found that over 90 per cent. of deaths from contagious diseases, such as diphtheria, scarlet fever, measles and whooping cough, occur before the age of ten, the mortality rate increasing, the younger the child. Thus you see the importance of the child escaping these diseases during the years of early school life.

In the face of such evidence as given above, to argue for medical inspection is to argue for increasing the efficiency of our schools, the protection of the community and the preservation of the lives of its children.

While medical inspection for the detection of contagious diseases is, primarily, for safeguarding the community, the work of physical examinations aims at securing physical soundness and strength and looks far into the future. It was instituted on account of the great mass of evidence showing that a large



percentage of school children, probably one-fourth to one-third of them all, are defective in vision to the extent of requiring an oculist's care, if they are to do their work properly and if permanent injury to their eyes is to be prevented. More than this, a considerable percentage (at least five (5) per cent.), are so seriously defective in hearing that their school work is badly interfered with. Most important of all, only a small fraction of these defects of sight and hearing are discovered by the teachers, or are known to them, to the parents or the children, themselves. Not only are eyesight and hearing important but there are many other defects, far from rare among children, and having an important bearing on their present health and future development which, if discovered early enough, may be easily remedied or modified. In every case where a defective condition is found to exist, the parent of the child is to be notified and advised to seek medical, surgical or dental attention if the condition is serious enough to need treatment.

Results of physical examinations in many large cities show that about two-thirds (2-3) of all school children were defective. Of course, all this does not mean that our schools are filled with physical wrecks. What the figures really do show is that more than two-thirds of the children are found to have defects serious enough to record them and which call for attention from a physician, surgeon or dentist. Still the defects, so recorded, may be nothing more serious than a carious tooth. It must be remembered in this connection that the perfect human animal is exceedingly rare.

In any system of medical inspection, which includes the feature of physical examinations, the keeping of records is of the greatest importance. There must be a complete individual record for each child. The record cards must have spaces for subsequent examinations, as well as the initial one. To be of practical value there must be the closest connection between these records and the class room work. The teacher should be aware of various defects in the child, especially as regards sight and hearing. The record should follow the child from room to room, and from school to school, in order to be most useful.

It is, of course, of the utmost importance that the physical defects, disclosed by the examination, be given attention by the parents of the child and, through them, brought before a physician and the defect remedied, if possible. It is of very slight practical use to discover that a child has enlarged tonsils.

or defective vision, if steps are not taken to correct the condition. Most all of these conditions could be cured, or prevented, if detected early in life, and the child could be rendered capable of making adequate use of the school facilities.

Study of the problem of retardation in school children leads to the conclusion that the greatest factor affecting the problem of the child's progress through the grades is that of regular and continuous attendance. Any influence which tends to reduce absence results in an increased use of school facilities, and so, in greater economy, a higher degree of efficiency and better education. Medical inspection, in greatly decreasing contagious diseases in the schools and in preventing or removing physical defects, will have a large and important influence in bringing about this greatly to be desired result.

In conclusion, to quote an extract from a memorandum of the London Board of Education:—

"Medical inspection aims, principally, at the physical improvement, (and, as a natural accompaniment), the mental and moral improvement of coming generations. If rightly administered, it is economical in the best sense of the word. Its justification is not measured in terms of money, but in the decrease of sickness and incapacity among children, and in the ultimate decrease of inefficiency and poverty in after-life arising from physical disabilities."

I wish to acknowledge my indebtedness in preparing this paper to Luther and Gulick's excellent work on this subject done under the auspices of the Russell Sage Foundation.

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### RAILROAD SANITATION.

BY

ANNA C. CLARKE, M. D., SCRANTON.

A DISEASE being necessary in order to provide rules for its prevention, it is obvious that hygiene must be largely dependent upon the advance made in pathology, aetiology and their allied branches.

With the introduction of the germ theory of disease came the awakening interest in the manner of conveyance, propagation and life of the germ together with its destruction. Thus each case of contagious and infectious disease becomes of in-

terest to the layman as well as the physician in charge. The treatment of an individual case is not and should not be a matter of governmental concern, except as it has a bearing on the public health; there is a wide difference between the treatment of a single case and the removal of the cause of such infection. Government activities are certainly exercised in a legitimate manner when they attempt through public hygiene to promote and conserve the life and health of its citizens. It is because of an acknowledged right and duty of the government to promote the general health that we have come to have local and State boards of health. These have made marked improvements in the public hygiene. The States each have their own rules and requirements in hygienic matters and are of as many different standards as there are in the medical education laws—let us hope that some day the federal government will have a department to superintend these important matters and bring about uniform requirements, restraining the impetuous and giving courage to the weaker States.

Great good has been accomplished by preventive measures and the supervision of public works and supplies. It is no longer possible for a person to maintain an objectionable or unhygienic condition on his premises which may be detrimental to the health and pleasure of his neighbor and no one would for a moment hesitate to hold that health officer responsible who neglected to correct such conditions. It certainly would not be considered an infringement of individual rights nor should it be so considered when the offender is a company of whatever nature.

For many years my attention has been called to the very unsanitary practice of railroads in using the roadbed as an open sewer—thus exposing the country to an infection of the diseases from which its passengers may be afflicted.

In order to make a more careful study of the subject I wrote to all the State Boards of Health and to all boards of health of cities of 100,000 or more population, asking what laws they had relating to railroad sanitation—and if any method was required to disinfect or otherwise protect the roadbeds from the sewage of passenger trains. I am greatly indebted for the most courteous and interesting replies to the presidents and secretaries of some thirty-nine States and thirty city boards of health—quite enough to give a very accurate status of the question.

It was with pleasure that some States report most advanced



work. Most States require proper ventilation of passenger coaches and that they be cleaned and fumigated with a prescribed disinfectant at stated times or after carrying contagious diseases. Cuspidors are provided on many trains and most roads prohibit spitting on the floor of cars.

New Jersey and Illinois should receive strong encouragement in their efforts to do away with the common drinking cup and like requirements in neighboring States would do much to secure the success of their efforts. In Illinois a law has been passed prohibiting drinking on the trains—this would seem to me to be a great hardship to the traveling public.

Nearly all railroads close their toilets on approaching and keep them closed until they leave the larger towns and cities; this is done either at the request of the local boards of health or by order of the railroads themselves to prevent the soiling of their roadbeds at stations. Most city boards of health report control of water-sheds supplying water for domestic purposes, while sanitarians throughout the country are putting forth every effort to provide for the disposal of sewage so as to protect our water sources and thus take care of our neighbor further down the stream, as well as to secure a valuable fertilizer and give a material aid to the restoration of the agricultural districts. These problems are most important and may well demand the best thought and endeavor. Improved sewerage and carefully protected food and water supplies, together with effective quarantine requirements have added greatly to the life of the cities and have done much to eliminate the so-called preventable diseases, most conspicuous among these is typhoid fever; that disease being traced to infection of the water supply more frequently than to any other source.

All city boards report as having a watchful care over this door of infection and when the local boards do not have supervision over water sheds, the State boards have come to their help, and have taken active measures in investigating and controlling all probable means of infection.

In most instances where epidemics of typhoid fever have existed and where the railroads have traversed the water sheds, the passenger trains have been considered a very eminent source of danger and the toilets have been ordered closed, as in the case of the epidemic in Scranton, Pa., a few years ago. There are two railroads crossing this water shed and running for miles on either side of the reservoirs supplying the infected

part of the city—the railroads were required to close the toilets by order of the commission of health and are still required to continue that precaution.

To illustrate the extent a city can go to protect its people, I wish to refer to the work so ably and vigorously prosecuted by Dr. Elmer E. Heg, commissioner of health of the State of Washington.

May 21, 1906, the City Council of Seattle passed an ordinance authorizing the mayor to give a deed for right of way through lands owned by the city on the watershed of Cedar River, to the Chicago, Milwaukee and St. Paul R. R., thus exposing the water system of Seattle to pollution during construction and to a continued danger from passenger traffic. The King County Medical Society asked the Superior Court for an injunction restraining the mayor from signing such deed. The medical society then secured the co-operation of the Chamber of Commerce, the Labor Council and the Commercial Club, these as a joint body induced the railroad to relocate their line further back from the river and make other improvements, but the sanitarians employed by the railroad were not satisfactory to either the State Board of Health or the King County Medical Society, so it was agreed by the city council and the medical society and its allies, together with the railroads, to abide by the decision of a sanitary commission composed of Dr. Chas. Harrington, Prof. of Hygiene, Harvard Medical College; Dr. A. C. Abbott, Prof. of Hygiene, University of Pennsylvania; W. G. Sedgewick, Prof. of Biology, Massachusetts Institute of Technology, and the State Board of Health was asked by all parties to render such assistance as was possible.

The State Board of Health therefore directed the sanitary engineer, Prof. W. J. Roberts, and the secretary to accompany the commission, and also to obtain the services of Mr. John R. Freeman, of Providence, R. I., a sanitary engineer of national repute.

In pursuance of the plan worked out by this joint commission an elaborate system of dykes, drains, filters, drained watertight railroad bridges, etc., were constructed, together with a system of constant patrol and a set of rules which enforce the closing of all railroad toilets on that railroad system while passing through the water shed.

I have quoted this at length to show how carefully the water sheds of cities can be protected when the medical profession be-

come aware of their power and responsibility. The greatest possible credit is due Dr. Heg and the King County Medical Society for setting so brilliant an example and encouraging the medical bodies to assume the responsibility and do their duty in the field of preventive medicine regardless of expense and labor.

The City of New York has almost unlimited control over all hygienic measures, closing the toilets on all trains crossing the water shed on approaching and passing through the city. Considering the long distance traversed it must be inconvenient to passengers, but certainly is better than polluting the roadbed. They are authorized to enter into contracts and agreements to provide for the disposal of sewerage of villages and townships within the Croton water shed to raise funds to carry into effect any sanitary protection of the water supply.

Several other cities report the purchase of large amounts of lands, removing hotels and furnishing watertight receptacles for boats and adjoining dwellings and providing for the daily collection of this sewerage.

Thus is shown the importance of the protection of the water supply of cities and the labor and expense given to secure such protection.

There is not so uniformly a favorable reply from the various State boards. There seems to be in many States a failure on the part of the legislatures to realize the importance of the work devolving on the boards of health and they fail to give the sanitarians the support so necessary to securing the best of results for the health of their people.

One State replies that they have no laws relative to the sanitary condition of railroads and it would be a brave man indeed who would dare to enforce any. Another that the legislature fails to recognize their advice and authority on any railroad question, all such matters being regulated by a railroad commission.

Some States say that the railroads were more ready to consider sanitary measures than the legislatures were to act with the health authorities in the matter. A few States replied that they were too young to have considered the question. All agreed that the rural districts and towns were given little protection and received no special supervision of water supplies or sewerage disputes unless called upon to take active measures due to some prevailing epidemic.

The Southern States find that hook worm disease is conveyed



by the same method as typhoid and are amenable to the same sanitary measures.

Several States report epidemics of infectious diseases occurring along water courses used for domestic purposes and traversed by railroads, the colon bacilli being found in the water of these streams and the only source of infection to be found was the passenger trains.

It is quite obvious that there are many difficulties in the way of fixing this responsibility, yet we are all aware of the number of patients suffering from enteric fever, either in the incipency of the disease or during convalescence, who hasten to their homes or seek recovery at our mountain and shore resorts. It has been demonstrated that a patient once infected with typhoid can be a means of spreading the disease for almost an indefinite time.

Typhoid has come to be recognized as a country disease, this is shown by the large number of cases occurring among the rural population, and also by the cases developing in those who have traveled or spent some time in the country on their return to their city homes.

Typhoid is an easily preventable disease and is always evidence of neglect of general sanitary measures and railroads can be held responsible for their share of the spread of the disease. The cities protect themselves while the trains are within its limits and crossing their watersheds at the great inconvenience of the traveling public and only make a dumping ground of roadbeds as the trains pass the smaller villages and rural districts.

Every person must use water in some form and they are entitled to have it as pure as can be obtained. The new earth along railroad tracks is especially favorable to washing the disease germ into the ground water, which according to Pettenkofen determines the spread of intestinal diseases. The subterranean water tends to convey any impurities to the nearest water courses. These diseases occur most frequently in the spring and fall of the year, at this time of the year we have the high water level succeeded by a fall, together with a high temperature in the soil air which is a condition believed to be most productive to the propagation of this class of disease.

All inland waters should be under the control of the State health authorities, and some system should be out that will protect the country water supply and not inconvenience the traveling public. Should the water sources escape infection, flies

and other insects are very willing carriers of the germs to the dwellings and deposits them on grain and fruit, to be later taken into the system.

Some of our States have recognized their duty in this matter and are endeavoring to solve the question in some practical way. We have seen some complicated methods work out in Washington for protection of the Seattle watershed, this is obviously too elaborate to be of general use. Oregon, Indiana and Montana are of the opinion that some device will be forthcoming which will meet this requirement, that anything less than complete protection by some sanitary device would be a poor makeshift.

There is another feature to such an appliance; they would enable railroads to keep the accommodations open to the passengers throughout the entire route instead of closing toilets at all large towns and cities, as well as when crossing the watersheds.

The State of New York requires closets to be locked on passing over five water supplies and sources. Some of the distances are for more than an hour of travel. Other States have like requirements. Our own Commission of Health, at the time of the Scranton epidemic closed the toilets of trains crossing the Elmhurst watershed, and kept them closed on one road until Glenburn was reached, a station some miles to the other side of the city, making in all about one hour's travel. This cannot help but be a great inconvenience, if not detrimental to travelers. In fact I have had instances occur with my own patients which were most annoying and distressing because they were ill and were deprived of the necessary accommodations.

The long interurban electric lines which traverse the thickly settled districts making long runs with such a device would add greatly to the comfort of their passengers and would more than compensate for the outlay by the increase in patronage.

Maine was the only State urging the provision of such a device for the benefit of elderly people, but it would seem to me we can all understand the injurious effects, as well as the annoyance arising from a lack of such accommodation and protection, enough to urge our railroads and health authorities to an early solution of the problem.

#### DISCUSSION.

DR. GAY: I have listened to this very interesting paper and

the following thought came into my mind, that the boards of health should be connected with the police department. This would give them full power to enforce necessary sanitary regulations. It should be borne in mind, however, that while we must give our health boards increased power to enforce their regulations, yet it will not do to go so far as to limit the liberty of the individual.

DR. BEATTIE: In dealing with railroad sanitation the problem is, whether we shall attack the nuisance in the cars per se, or attack it in the road beds and in the water supplies. It would seem that the solution of this problem would involve the taking care of the sewerage in the car. It is probable that some electrical process may be devised for this purpose.

DR. PURCELL: It seems to me that this problem is one of education. We cannot force people to do certain things, but we must educate them to do these things. If you have visited the City of Portland you will be struck with the sanitary conditions of that city. Upon inquiry I was told that the police are instructed to enforce sanitary laws. Various receptacles are provided throughout the city and decayed food and other refuse must be placed in these receptacles.

DR. HILLS COLE: The difficulty in solving these questions is to get our legislators to back up the sanitarian in his efforts for the public good. The power of the purse is the thing that you have to fight. Certain men in the cities have interests that would be injured if an attempt were made to enforce sanitary measures. As the last speaker said,—“It is largely a question of education.” A great deal is said sometimes in criticism of health boards, and the questions are asked, “Why do not they do this?” Or, “Why do not they do that?” There are two things to say in reply: In the first place, very often the health departments do not have the power they are assumed to have. For example, the board of health in the State of New York has very little power at all. Some one spoke about the sanitary conditions of Portland. In these newer communities it is very much easier to have the sanitary laws enforced. In older communities it is the work of a lifetime to introduce newer ideas, and it is necessary to proceed slowly. Not only is it necessary to have legislation passed, but you must educate the people so that they will support you in enforcing the law. The essayist made the statement that the water supply was the greatest cause of typhoid fever. Now this is true in a sense; in another sense it is not true. Given a hundred cases of typhoid fever, it is probably true that the majority of cases have been brought about by an impure water supply; but, if you take one hundred cases of typhoid fever not occurring in a single epidemic or, as



they occur in a community during the course of the year, and then analyze their causes and you will find that the water supply has not been at fault as frequently as other conditions, such as fly infections, etc. The question of protecting the rural communities is one of great interest, and in New York State we endeavor to do that. Our sanitary inspectors go over the water sheds and if they find something that needs attention they advise the local community and endeavor to have the matter corrected. The Board of Health of Pennsylvania has considerable power under the law, but it is a matter of comparatively recent creation, and those who created the department took into consideration the powers granted to the boards of health in a large number of other States.

DR. MILLER: It seems strange to me that the board of health should vaccinate the children of the State of Pennsylvania and yet never raise its hand against the spread of prostitution in our largest cities and never attempt to prevent the spread of three diseases that are generated in these places. Now, is that not evidence that the State Board of Health does not use the power that it has for the purpose of suppressing the diseases that are present? I sometimes question whether doctors who, when they talk sanitation, are sincere. I have attended sanitary meetings and read sanitary papers and felt that there was nothing before me but starvation, and yet, when I spent my vacation this summer in the country I saw nothing but graveyards and stone fences. Notwithstanding the efforts of the board of health and the millions of money they have spent I do not see that the aggregate death report is any less. And that is the reason why I think that the boards of health are arrogating to themselves a great deal that they are not entitled to. The doctor tells of a half dozen sources of typhoid fever besides the water supply. Milwaukee rid itself of typhoid fever by getting a new water supply, and everybody in recent years says that it is impure water that causes typhoid fever. Now the doctor tells us it is no such thing. That you can trace a few cases to the water, but a great many more to something else. If it comes in the water supply it is an accident; if it comes in something else it is an accident, and when we talk of sanitation to prevent infection and then indulge in every excess that we can possibly think of, it seems to me that we have got hold of the wrong end of the stick.

DR. HILLS COLE: Dr. Miller has commented on your State Department of Health, and I want to say one word on that point. He asks why they have paid so much attention to small-pox and none at all to such diseases as syphilis and gonorrhœa. The answer is that public opinion is in favor of the prevention

of small pox; as yet you do not have public opinion back of the prevention of syphilis and gonorrhœa.

DR. CLARKE: I am very glad to have brought out some general expression of opinion concerning this subject. I think that there are many cases of typhoid fever that are conveyed by flies and from milk infection. At the same time I believe that the water supply is by far the most important source of infection.

## BUREAU OF OPHTHALMOLOGY, OTOTOLOGY and LARYNGOLOGY

S. B. MOON, M. D., Chairman

### THE X-RAYS IN DISEASES OF THE EYE.

BY SEYMOUR B. MOON, M. D., PITTSBURGH, PA.

REALIZING the uncertainty of the action of X-rays, I feel we should be very conservative in its use; knowing for a fact that in some diseases of the skin, especially epithelioma, they cause the lesion to progress more rapidly, while in others to regress and entirely disappear. So far as I can learn there are no means of knowing beforehand what the results may be. It is only a trial of the treatment in each individual case that will determine whether it should be continued.

A case of marginal ulceration of the cornea that responded favorably to this treatment, came under my observation on October 3, 1910. Mrs. N. R. S., age 64, neurasthenic, frail, and poorly nourished, has been subject to a slight bronchitis for many years. Three years ago she received an injury which was followed by an attack of neuritis in the back extending into the left sciatic nerve. Several months later a neuritis in the left brachial plexus developed and was benefited by galvanism. For the past eight months has been suffering with severe neuralgic pains in the head and eyes, photophobia and lachrymation. The tension was normal in both eyes. Inspection of the left eye showed it to be in a good condition, having a vision of twenty thirtieths. The vision in the right eye was twenty-two hundredths. The conjunctiva was hyperæmic, a pericorneal injection was present, and a peripheral zone of infiltration, two

millimeters wide, and extending two-thirds around the cornea. It was located on the lower and nasal portion. A superficial ulcer, one-half by one and one-half millimeters in diameter, was situated in the lower portion of this infiltrated area.

The right inferior turbinate was hypertrophied and good sized excrescences were located on the anterior and posterior tips, causing almost a complete stenosis of the right nares. The left side was normal. This condition of the nose leads me to suspect that it was at least a contributory cause of the keratitis. A turbinotomy was done and the nasal trouble cleared up promptly, but later results did not prove it to be an accessory cause of the keratitis.

For the eye scopolamine 1-500, iodoform ointment ten per cent., and hot fomentations were used locally, and hepar sulphur 3x internally. After two weeks time the ulcer of the cornea had healed and there remained a complete zone of infiltration, dotted by numerous small areas of greater infiltration, giving it a punctiform appearance. A week later one of these infiltrated areas broke down and became a superficial ulcer one-half by one millimeter in size. Ten days later the excavation had disappeared and the ulcer healed. This process of ulceration, always located in the periphery of the cornea, but gradually approaching the pupillary area, continued for a period of about eight months. I was never able to detect any elevation over these densely infiltrated areas, they seemed to break down and excavate in one night's time. Iritis was present as some posterior synechias could be seen. I had sufficient time to try all kinds of local treatment and internal medication. Locally I had used atropine, scopolamine, dionin, calomel powder, ointment of yellow oxide of mercury, oxycyanate of mercury, bichloride of mercury, and argyrol in ten and twenty-five per cent. solutions. At different times the ulcers were treated with tr. iodine, phenol, and the galvano-cautery. Internally gelsemium, cedron, aconitine, calc. sulph., sulphur, mercury, kali iod., rhus. tox., and arsenicum were given. Cod liver oil and forced nutrition were tried out pretty thoroughly. Aspirin ten grains was allowed for the severe pains, always giving relief for several hours.

Bacteriological tests were made by Dr. Frederick S. Morris, one of the tests showed the presence of tubercle bacilli, the other tests were negative. No culture or biological tests were made, so that I do not believe that the tubercle bacilli should be held



as the etiological factor, for I understand it is difficult in corneal ulcers to differentiate tubercle bacilli and the bacillus of Zur Neddin without the above tests being used.

The patient had suffered from so much pain, loss of sleep, and depleted appetite that she was in a highly nervous state and willing to make any sacrifice to get well.

I did not feel justified in doing an enucleation, for the vision was still very good, being ten two-hundredths. During the months of July and August the patient was placed under the care of Dr. E. H. Pond for X-ray treatment, continuing the same time the use of yellow oxide of mercury and atropine ointment twice daily and aspirin ten grains when needed for severe pains. During July the severe pains in the head and eyes had been greatly relieved, so that now the aspirin is used but twice in twenty-four hours. No new ulcerations have occurred since, and the opacity of the cornea has cleared up a great deal around the pupillary margin. The vision has come up to twenty fortieths, but vessels from the conjunctiva extend over the margin of the cornea, causing the diameter of the cornea to appear much smaller than the healthy eye. There still remains a modified form of hyperæmia of the conjunctiva and some ill effects of this treatment which have caused the loss of the cilia on the lower eye lid. The number of X-ray exposures were sixteen of ten to fifteen minutes duration, the tube being placed one-half to one inch from the eye.

The second case, one of papillomatous degeneration of the conjunctiva, was first seen by me on March 2, 1910. Major D. D. B., age 73, tall, slender, and poorly nourished. For years he has had arterial sclerosis with valvular lesions of the heart, and chronic bronchitis. The vision in the right eye is twenty two-hundredths. For three months his daughter has noticed a growth on the conjunctiva and cornea in the right eye. There has been a muco-pus discharge in the eye in the mornings which has disturbed his vision. The growth was located on the lower and nasal side of the bulbar conjunctiva, occupying about one-sixth of its area. Its edges were sharply defined and were two millimeters higher than the surrounding healthy conjunctiva, having a granular appearing surface of a pinkish color, evidently due to enlarged papilla. There also seems to be a collection of epithelial cells on the top of each papilla. This growth extended over the lower and inner segment of the cornea, and covering a greater portion of the pupillary area, it

lacked the vascular tissue here, and hence the pinkish color was absent in the corneal portion. The growth was removed from the cornea by curettement and the diseased conjunctiva excised. The edges of the wound were approximated and held by silk stitches. The wound healed promptly and without leaving any opacity of the cornea. During the following six months small patches of this tissue appeared at intervals on the periphery of the cornea and were removed with the curette. Six months later, or a year after my first observation, the patient presented himself with the growth covering the entire bulbar, the lower palpebral conjunctiva, and the periphery of the cornea extending to the pupillary margin. An indurated mass was present in the lower fornix, which felt like a cartilaginous ring between the orbit and the eye ball, this being the cause of a well developed ectropion. The eye ball was almost fixed, only slight movements of the bulbus remaining. This time the abnormal tissue was removed from the cornea, and the patient referred to Dr. E. H. Pond for X-ray treatment. I had used locally in this case—argyrol ten and twenty-five per cent.; adrenalin one to one thousand, and protoneuclein (special); internally arsenicum alb. and thuja were given. During June and July eighteen treatments were given of ten to fifteen minutes duration. The results show a complete loss of the cilia. There is no sign of the growth except a slight induration in the lower fornix, and a few dilated vessels in the conjunctiva; the cornea is perfectly clear and the lower lid is in a normal position. The eye ball is fixed and the lense is growing opaque. The vision is now seven two-hundredths in the right eye. In the left eye light perception only. The last treatment was given July 24th and so far there is no sign of a return of the growth.

Physically the patient is very weak, but I am hopeful that he may live for some time, in order that the results of this treatment may prove to be not only temporary but permanent.

I am indebted to Dr. Frederick S. Morris, pathologist of our hospital, for the diagnosis in this case. I feel that the results obtained in cases cited give us additional proof of the efficiency of X-ray treatment in these diseases, and I shall be satisfied if, by reporting these cases, I may have added a little in support of this treatment in these apparent difficult lesions.

Ball. Modern Ophthalmology.—Papillomata spring from the caruncle. They are composed of connective tissue and blood vessels, and bleed easily. They are not smooth like polypi,

but present a papillary, nodulated, or cauliflower-like appearance. They have a broad base, and are likely to recur. In rare instances they undergo carcinomatous degeneration.

Weeks. Diseases of the Eye. Papilloma.—Tumors of this nature exist as small multiple papillæ, forming soft, pale pink, villous masses. They may develop from any part of the ocular or palpebral conjunctiva, but are seen most commonly on or near the caruncle. Papilloma is not infrequently mistaken for granulation tissue. To avoid recurrence, removal must be thorough.

Woods. Ophthalmic Therapeutics.—Birch-Hirschfield points out that unless the Roentgen rays are used with proper care they may occasion loss of the eyebrows and eye lashes, burns of the conjunctiva and conjunctivitis, and inflammation of the cornea and iris. Intra-ocular injuries may also follow, such as degeneration of the macular region and ganglionic layer and vessels of the retina, and of the medullary fibres of the optic nerve. He consequently suggests that the eyeball should be properly protected and that exposure to the rays should neither be too protracted nor too frequent.

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### LABYRINTH SEQUESTRATION.

BY

G. W. MACKENZIE, M. D., PHILADELPHIA.

ALTHOUGH the particular case that I am about to report is a rare and interesting one, we cannot consider the pathologic process present in the temporal bone as belonging to a class of diseases that is rare.

Koerner<sup>1</sup> points out three distinct pathologic processes that may occur in the temporal bone as the result of purulent infection: 1, empyema; 2, softening and dissolution of the bony substance; 3, necrosis. (Fridenwald.<sup>2</sup>) Of these three conditions the first is by far the most frequent; the second less frequent, and the last (necrosis) the least frequent. According to the above mentioned authors necrosis occurs decidedly less frequent than caries or as 6 (necrosis) is to 100 (caries).

Caries and necrosis may occur independently or co-incident-

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1. Koerner. "Die eitrigen Erkrankungen des Schafenbeins." Wiesbaden, 1899.

2. Fridenwald. "Fetid necrosis following the simple mastoid operation."



ally. Necrosis may involve any or all of the bony walls of the tympanic cavity. It may be quite superficial or it may extend deeply into the bone. It may be so extensive as to include the greater portion of the temporal bone; indeed in some rare cases the process of necrosis may extend to the neighboring cranial bones and even to the vertebræ.

Neither Politzer<sup>3</sup> nor Bezold<sup>4</sup> make the finer distinction that Koerner does. They do not describe caries and necrosis of the temporal bone as separate, but as associated pathologic processes.

Politzer, page 513, English translation, describes them under the heading—"The Carious and Necrotic Affections of the Temporal Bone Which Develops in the Course of Suppuration of the Middle Ear;" while Bezold describes them under the heading (page 228) "Die eitrige Mittelohrentzündung der Phthisiker (Otitis media purulenta phthisica). Karies und Nekrose des Mittelohrs." (page 234) "Die übrigen Formen von Karies und Nekrose des Mittelohrs."

Furthermore, in the English translation of Politzer's book, page 525, he says, "the size and form of the sequestra depend on the site and extent of the caries."

Since caries and necrosis are complications secondary to middle ear suppuration, naturally the extension of the process is favored in those cases where the mastoid cells are distinctly pneumatic and where the mucous membrane lined cells extend far into the petrous bone. The diploe is less likely to yield to the process of caries and necrosis and the compact bone the least of all.

Caries and necrosis of the temporal bone is prone to occur in the very young and the very old. The conditions which favor caries and necrosis are both general and local. Among the general or systemic conditions may be mentioned tuberculosis, syphilis, diabetes, grave constitutional diseases which lower the vitality and impair the power of repair, etc. Among the more common local conditions are cholesteatoma, cicatricial adhesions, obstructive diseases of the external canal, polypi, etc.

Politzer claims that the formation of a sequestrum in the temporal bone generally takes place slowly, but sometimes very rapidly however, in scarlatinal diphtheritic forms of otitis.

3. Politzer Lehrbuch d. Ohrenheilkunde.

4. Bezold Lehrbuch d. Ohrenheilkunde.

According to Heike,<sup>5</sup> whom Politzer quotes, "The surrounding glands and lymphatics of infants with aural tuberculosis are more often involved than in adults, and destruction of bone also takes place sooner."

Poltizer, page 517 (English translation) claims that "In consequence of caries of the temporal bone, extensive swelling of the lymphatic glands on the side of the neck as well as inflammatory areas and abscesses in the neighborhood of the ear are occasionally met with," and he further claims that Ferreri frequently saw a middle ear suppuration in children extend to the parotid gland and to the joint of the inferior maxillary bone.

Concerning the frequency with which facial paralysis is found associated with necrosis of the labyrinth, Bezold claims 83 per cent.

In reporting the following case I do not presume to add anything new to our present knowledge of the subject. I am prompted rather for these reasons:—

First.—I believe it to be the duty of every physician to report carefully all rare and interesting cases in the interest of science.

Second.—Because of the extremely tender age at which this child was affected.

Third.—Because of the severity of the complications which were present.

Fourth.—Because of the wonderful recuperative power manifested by some patients (this one included) when apparently desperately sick.

*The Case.*—Name, J. G. J., age 5 months, referred by Dr. Geo. C. Webster, of Chester.

*Diagnosis.*—Subacute middle ear suppuration of the left ear with mastoiditis; complete facial paralysis and multiple cervical adenitis of the left side of the neck.

*History.*—The child was born normally of healthy parents with negative family history (furnished by the family physician). At the age of two months the child began with swellings in the neck on the left side (cervical lymphatics) which steadily increased in size. Shortly afterward the left ear began to discharge. On close questioning both the family physician and the mother insisted that the discharge from the ear did not precede but followed the swelling in the neck; however, the lapse of time between the two occurrences could not be recalled exactly.

5. Heike, *Deutsche Med. Wochenschr.* Vols. X, XI.

The discharge from the ear appeared one morning after a night spent in restlessness and crying apparently from pain, which the mother can recall distinctly. The discharge has continued, varying in amount, up to the date of this, first consultation. It was thought by the family physician that the ear discharge might possibly be due to suppuration into the ear of a nearby gland. A very large suppurating preauricular gland which extends to and apparently surrounds the anterior and inferior margin of the external meatus. Facial palsy followed close after the aural discharge and progressed to complete paralysis. General health of the infant was below par, but not markedly so. The baby had been fed after the Starr formula.

*Present Condition.*—The child is somewhat smaller and weaker for its age than a normal child should be. The internal organs are quite normal (information supplied by Dr. Webster). Neck shows many of the cervical lymphatic glands enlarged, two of which are the size of a walnut, one directly below the ear is fluctuating and red for an area of half a dollar, and the overlying skin is thin and immovable. The other large suppurating gland is pre-auricular and had already ruptured. Behind the auricle there is a fluctuating swelling over the antrum about the size of a small hickory nut. The auricle stands out from the head in the more or less characteristic position as found in older patients. The retro-auricular fold being absent.

Examination of the left ear revealed profuse brown colored, thin, foetid discharge—the odor characteristic of necrotic bone. After cleansing away the discharge the canal was found to be **narrowed because of thickening of the skin**, due no doubt to the irritation of the discharge. We naturally would not expect to find the typical sinking of the posterior upper wall of the osseous canal in a child so young, since the osseous canal is not yet developed, at this age being extremely short. The membrane was completely destroyed and the anatomical details were not discernable owing to the presence of granulations. With the probe raw bone was detected.

Examination of the right ear showed normal findings.

Functional examination of the cochlea, and semi-circular canals was impossible in a child of this age, besides, during the greater part of the time spent in examination the child cried. The child's crying, however, afforded an excellent opportunity to examine the face. The muscles of the affected side were inactive. The orbicularis palpebrarum muscle was absolutely in-



active as were all the other mimic muscles. There was apparently hyper-secretion of tears on the affected side. There was no congestion of the conjunctiva and the cornea was moist and reflected a brilliant light image.

Operation was performed on the following day at the Crozer Hospital, Chester, Pa. Typical retro-auricular incision 4 c.m. long down to the bone. The periosteum was elevated behind the incision and in front to the canal. This was easier to accomplish, than in the average case. The bone over the antrum was soft and necrotic so that with the curette it was easy to remove **and thus enter the antrum.** The greater portion of the annulus tympanicus separated in one sequestrum. The external attic wall was removed with the anatomical forceps. The antrum was curetted of granulations. Here and there small pieces of dead bone which lay loosely in the wound cavity were readily **picked out with the forceps.** By probing the tegmen tympani and tegmen antri both were found intact and covered with mucous membrane. Raw bone was detected with a probe in the region of the Eustachian tube, but it was decided that it would be better left alone for fear, that by removing it, we might have a fatal hemorrhage from the internal carotid. Plastic operation after Panse was performed and the retro-auricular wound was not closed. Next the glands were attacked. The suppurating pre-auricular gland was opened freely and curetted, likewise the suppurating gland in the neck; both contained pus and the latter cheesy material. A few other of the larger glands were extirpated, wound dressed with iodoform gauze and bandage.

April 17th, the day after the operation the temperature was 103 in the axilla, child nursed regularly and slept well.

April 18th, temperature 98.4, respirations 24, pulse 112, child slept and nursed regularly. The child's immediate recovery was all that could be expected. Until June 19th, the discharge from the external canal and retro-auricular wound continued profuse and offensive, suggesting further bone necrosis. A second operation was suggested, but was postponed by the family until July 20th.

At this time the retro-auricular wound was about large enough to admit a slate pencil. About the orifice were some exuberent, pale colored granulations. From the fistula issued a dark ichorous and very foul smelling discharge. With a probe I was able to detect raw bone deep in the cavity.

Second operation was performed at the Crozer Hospital, July 21st, 1910. The line of incision followed the scar left by the first operation. The fibrous tissue which had formed since the former operation was curetted away and we were soon in a good sized cavity containing quantities of dirty, gray, soft granulations and small gritty black particles. Embedded in these were larger and smaller pieces of dead bone which were readily removed with anatomical forceps. In all perhaps there were 8 or 10 irregular shaped pieces of dead bone, varying in volume from that of a pea to a jack stone. The bone surrounding the carotid was removed, leaving the knee and horizontal section entirely free. The tegmen tympani and antri, denuded of muco-periosteum, were readily removed exposing the dura of the middle fossa, which was found to be covered with bright red granulations, bleeding easily. These were decidedly more healthy looking than the granulations which were first met with in the original cavity. The lateral sinus was already exposed by reason of the existing careous and necrotic process. Some extra pieces of necrotic bone which were loose were removed posteriorly to the sinus. Covering the sinus and part of the dura of the posterior fossa were granulations resembling those which covered the dura of the middle fossa. The cavity was washed out with peroxide of hydrogen, followed with water several times during the operation, and careful researching for the small dust like particles and the larger sequestra. During the operation neither the chisel nor burr was used. The only thing left of the petrous bone after the removal of the sequestra and careous particles was the internal auditory canal which was found to be in good condition. Remarkable as it may seem there was no escape of cerebro-spinal fluid during or after the operation. The probable explanation is that nature had thrown out protective barriers in the form of granulations shutting off the preformed ways to the cranial cavity.

The original wound was enlarged in a downward direction to expose some cervical glands which had enlarged since the first operation. These were removed and found to be about the size of hulled walnuts.

Wound dressed with iodoform gauze and bandage.

The after treatment was faithfully looked after by Drs. Geo. C. Webster, Sr., and Jr., to whom I owe many thanks for their able assistance.

The wound cavity began to fill up promptly and epidermis

migrated toward the cavity backward from the external auditory canal. From the time of this second operation the discharge lost its foul odor and gradually diminished in amount. The retro-auricular wound was slow in healing. It was not entirely closed until about 7 months after the second operation.

The child's general condition of health improved up to a certain point and then remained quite stationary. A few months after the second operation the cervical lymphatics again began to swell so that by March, 1911, the glands were enormously swollen, when it was decided to remove them. To this the family readily consented.

On March 19th, 1911, the child was submitted to the third operation, which I will cite briefly. In all about twelve to fifteen infected glands which extended from the external auditory canal to the sternum were removed; they varied in size from a marble to a walnut. One of these glands, in spite of precautions, unfortunately ruptured. The contents of all the glands were distinctly cheesy. These were put aside for pathologic examination, but unfortunately were lost or thrown away by the nurse.

There are some features concerning the results of this third operation which can be better told by Dr. Geo. C. Webster, who looked after the after-treatment, than myself. His report is as follows:

"The case was a desperate one. Operation seemed to be the only hope of saving life, and that a forlorn one, and had it not been for the brave adherence to principle by Dr. Mackenzie, I fear the operation would have been deferred until after a post-mortem examination had been made. Our little sufferer, however, surprised us in many ways. He stood the shock of anæsthesia (chloroform) and operation very well. The axillary temperature the following morning was 103 F, but by evening (under Acon. R. 3x.) it had reached the normal line and did not depart much from it afterwards. The dressings were not disturbed until the sixth day after the operation, by that time the canal dressing was saturated with pus, the wound bled by slight probing. Daily dressings were applied until May 10, 1910, by this time pus was flowing freely from both canal and wound, and had an offensive odor, so that thorough irrigation and redressing was done twice a day until the time of the second operation, July 21, 1910. From this operation he recovered rapidly, and by September 10, 1910, the wound was closed



but the canal was still cleansed frequently. The enlarged lymphatics in front and below the ear were enucleated March 19, 1911, and have entirely healed. There is now no open wound and no discharge, and the ear requires no attention. Aside from some digestive disturbances he has enjoyed good health since the last operation. Calc. Phos., Graphites, Silicea and Mercurius have been the remedies used during his illness. At present the child is enjoying fair health, he is somewhat under weight, but can walk alone, talks some and is playful. The facial paralysis is not a marked deformity while the face is restful, but is prominent when he laughs or cries."

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**RAPID CURE OF GONORRHEA.**—Dr. A. C. Magian outlines a new rapid method of curing gonorrhea (*Brit. Med Jour.*, June 24). It is certainly a heroic and troublesome method, but if it will do what Dr. Magian claims it will, it is worth while trying.

The treatment consists of large (3 gallons) irrigations with 1-5000 potassium permanganate, followed by a similar washing with distilled water, then 3 gallons of water containing 1 ounce of protargol, 30 grains of chlorid of gold in 1 quart of water and repeated irrigations with one-half per cent. protargol in the course of the next twenty-four hours. These irrigations are repeated in increasing strength on the second, third and fourth days. On the fifth day, use 3 gallons of weak sulphate of zinc solution, and on the sixth day a similar amount of weak nitrate of silver. The exact strength of these last irrigations varies according to the severity of the case. The cure is said to be almost invariably complete. In a very few instances an additional day or two is required. Microscopic examination of urethral swabs reveals no gonococci at the end of the week, and there is no trace of any discharge. The urine shows no threads or any other deviation from the normal. Magian has used this method in 100 consecutive cases, and in only three instances was a cure delayed beyond the seventh day.

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**A RESEARCH IN CHLOROSIS.**—Morawitz (*Munch. Med. Wochenschrift*) draws the following conclusions from his studies of chlorosis:

1. There are frank cases of chlorosis with a normal or nearly normal blood finding. These cases are not rare. They are as favorably influenced by iron as are the cases with a distinct anemia.

2. The anemia is not the cardinal symptom of chlorosis, but is only one of a group of symptoms.

3. Disturbances of menstruation, venous hum and the water retention of chlorosis are not always dependent upon the anemia, but are in a majority of cases subjective symptoms.

4. It is not proven that iron acts in chlorosis as a stimulant of the blood producing organs or especially as a stimulant for the increase of hemoglobin. The uselessness of iron in nearly all the anemias not chlorotic in type speaks against its having such a stimulating effect.

## EDITORIAL

## THE TREATMENT OF PNEUMONIA.

If the medical literature on the treatment of pneumonia were collected together it would probably fill several volumes. Almost every month some physician announces that he has discovered a new specific for the cure of this affection, and at the present time there would seem to be almost as many specific remedies for the cure of pneumonia as there are physicians.

In contrast with the optimism of the many, however, is the pessimism of the few, who have gone so far as to declare that there is no medicine of any value in the treatment of pneumonia, and in fact, that there is very little to do for a pneumonia patient therapeutically. Such therapeutic nihilism certainly cannot be concurred with by those who have availed themselves of aid of homœopathic medicine.

A great deal that has been written about the treatment of pneumonia is sheer nonsense, and the practical physician will do well to avoid the various fads and fancies that are constantly being exploited in connection with this disease. There are, however, certain therapeutic procedures of well-established value, and the physician can apply these with the confident expectation of accomplishing all that can be accomplished in a therapeutic way.

Briefly stated, these measures are,—rest in bed, an easily assimilated diet, a free supply of fresh air, and the homœopathic remedy. Rest, in the treatment of a pneumonia patient, should not be merely nominal, but actual. A patient should be confined entirely to bed, and the visits of talkative friends and of hysterical relatives should be strictly interdicted. We must bear in mind that in this disease we have to deal with a bacterial infection which the protective forces of the body are struggling to overcome. It is, therefore, essential that every source of mental or physical exertion should be avoided in order that the protective mechanism of the body may be given ample opportunity to direct and to utilize all the energy of the patient

for the purpose of overcoming the invading micro-organisms and their toxins.

We should not forget that sleep is an important part of rest and every measure should be employed to promote proper periods of quiet and restful sleep. Should the patient pass through several sleepless days and nights in succession, his chance of recovery is seriously impaired, and we are of the opinion that under such circumstances sleep should be induced even by drugs if necessary. Fortunately, in the vast majority of instances, by the use of tepid sponge baths or by bathing the feet in very hot water for ten or fifteen minutes before bed time, we can induce sleep.

The feeding of a pneumonia patient is ordinarily a comparatively simple matter. Lobar pneumonia is a disease of short duration and the patients stand a low diet very readily. Ordinarily, milk, junket, vegetable and meat broths, orange juice and albumin water can be administered freely.

These patients should be given water frequently, and if it is possible to keep the quantity of urinary excretion above three pints per day, we can feel quite sure that good elimination is being secured. Careful observation would seem to indicate that patients who excrete a large quantity of urine are likely to make a good recovery. It is a mistake, however, to force a large amount of water into the patient when we have to deal with a seriously impaired heart or where the amount of urinary excretion fails to increase in proportion to the extra amount of water administered.

A free supply of fresh air is an extremely important therapeutic procedure in the treatment of acute lobar pneumonia. Inasmuch as the amount of lung space available for oxygenating the blood is diminished, it becomes all the more important that the air that is breathed into the lungs should contain a full percentage of oxygen and be free from carbon dioxide and other impurities. Ordinarily such a supply of fresh air is best secured by placing the patient in a fairly large room with one or more of the windows partially open and an open fireplace with a wood fire. This assures a continuous and steady removal of the impure air from the room without causing an excessive draught. The temperature of the room should be maintained as nearly uniform as possible. In our experience, a temperature of from sixty to sixty-five degrees is most desirable.

While fully appreciating the immense importance of pure air



for pneumonia patients, we can see little reason for treating these patients on the top of the roof or on open porches during the winter months, as has been so strenuously advocated by many medical practitioners.

The indicated homœopathic remedy as far as the medicinal treatment of pneumonia is concerned, so far surpasses in its results all other forms of medication in the treatment of this disease that no other medicinal treatment need be seriously considered.

All old school authorities of any prominence are agreed that alcohol, digitalis, calomel, tartar emetic, creosote and the rest of the so-called specifics for pneumonia are worse than useless. The mortality rate in this disease is, and has always been, lower under homœopathic treatment than under any other known method of medical treatment.

It is needless to say that, from a homœopathic standpoint, there is no specific for pneumonia. Each case must be prescribed for upon the individual symptoms that are present. We cannot, however, dismiss this phase of the subject without bearing testimony to the wonderful therapeutic effects of bryonia in the treatment of this disease. That thousands of lives have been saved by the administration of this remedy in pneumonia by homœopathic physicians cannot be doubted by any one who will carefully investigate the statistics of this disease.

Had homœopathy done nothing more for the practice of medicine than demonstrate the therapeutic value of this remedy it would have earned for itself an honorable place in medical history.

G. H. W.

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#### THE TREATMENT AND PREVENTION OF MEASLES AND SCARLATINA.

The remarkable results that Milne claims to have secured in the treatment of scarlet fever and measles are such as to challenge attention and to invite careful investigation of his claims.

In his article in the *British Medical Journal*, (September 2, 1911,) he states that he has records of eight hundred cases of scarlet fever treated in accordance with his method without a single complication of any kind. He further states that the spread of the disease never occurs if his method is adopted, and

that patients suffering from scarlet fever may be nursed side by side with healthy children without any danger of contagion.

He describes his method of treatment as follows:

"As early as possible in the disease, without waiting for definite diagnosis in doubtful cases of scarlet fever or measles, the tonsils and the pharynx, as far up and down as can be reached, are swabbed with ten per cent. carbolic oil every two hours for twenty-four hours. It is rarely necessary to continue the swabbing for a longer time. The swab should be of cotton wool held by forceps or fixed to a piece of wood by a thread. In addition the patient should be rubbed all over with pure eucalyptus oil, from the crown of his head to the soles of the feet. This injunction is repeated morning and night for six days, and once a day for the six days following."

The advantages of this treatment, the writer states, are that secondary infection never occurs and consequently complications are unknown; the treatment may be carried out in a room with other children without the risk of infection; no after disinfection is necessary, for the disease having been destroyed nothing remains.

Such results seem rather incredible at first hearing, but Dr. Milne's statements seem to have the backing of a considerable number of medical practitioners, and a test that has been made at Clydebank seems to largely confirm the claims of the writer.

Should the method prove anything like as effective as Dr. Milne states, it will be a decided advance in the treatment of these common and dangerous affections.

G. H. W.

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**Homoeopathic Medical Society of the State of Pennsylvania,—  
Annual Meeting for 1912 at Delaware Water Gap, September 17, 18  
and 19.**

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**American Institute of Homoeopathy,—Next Meeting at Pitts-  
burg, Pa., June 16th to 22d, 1912.**

## GLEANINGS

**APIS MELLIFICA.**—By Walter Sand Mills, A. B., M. D. *Apis mellifica*, the honey bee, has long been known to have an unpleasant way of indicating his displeasure with his sting. The virus when injected sets up a decidedly disagreeable local irritation with swelling, heat, and redness. Occasionally animals, and sometimes persons, have been stung to death by a swarm of bees.

In Hering's "Guiding Symptoms" it is stated that in 1835 a Rev. Mr. Brauns, of Thuringia, published some cures made with the pure bee poison, in a popular homœopathic paper. In 1853, in a supplement to volume III of the *North American Journal of Homœopathy*, there was published a complete proving of *apis* by the Central Homœopathic Society of New York, together with a number of clinical cases. The proving was made under the supervision of Dr. F. Humphreys, of Utica. The preparation used was prepared by putting a number of live working bees in a glass jar and pouring alcohol on them. After a time the clear liquid was decanted off. This was the tincture. The proving of this preparation then published is the basis of the pathogenesis now found in the homœopathic text books on *materia medica*. Hering's marked verified symptoms were made with the pure virus.

Common table salt is said by Hering to be an efficient antidote to bee stings or to large doses of *apis*, *natum muriaticum* (potentized salt) to small doses.

Clinically, *apis* is of use in edema, local or general. In the edema of Bright's disease *apis* is one of the best of remedies. It sometimes takes a day or two for it to begin to act, so immediate results must not be expected.

*Apis* is also of value in acute suppression of urine, without edema, when due to nephritis. In either of the above conditions an increased flow of urine shows that the *apis* is taking hold.

In local edema of the genitals, either of the prepuce or of the pudenda, *apis* is a valuable remedy.

In erysipelas with much edema and pale skin *apis* is indicated.

In urticaria *apis* is almost a specific. I have used it in a number of marked cases with the most prompt and gratifying results.

In a remarkable case of Schönlein's disease, *purpura hæmorrhagica rheumatica*, *apis* cured the case in a few days after other remedies had failed.—*The Pacific Coast Journal of Homœopathy*.

**APPENDIX DYSPEPSIA.**—Formerly the cause of chronic stomach trouble was always sought in the stomach itself and our therapeutic measures were always aimed directly at that organ. It is only in recent years, says W. F. Cheney, San Francisco (*Interstate Medical Journal*, October), that a chronically inflamed appendix or gall-bladder has been recognized as a cause of dyspepsia. When we see how many observers, working inde-



pendently in different parts of the world, have come to similar conclusions regarding the existence of an appendix dyspepsia we are forced to believe that the condition must hereafter be reckoned with as one of the possibilities in all chronic disturbances of digestion. If we seek for any typical history of this condition we shall be disappointed, says the author. Some cases show in their history a striking resemblance to gastric ulcer, with epigastric pain after eating, flatulence, belching, sour eructations, nausea and vomiting, and even hematemesis at times. These are the cases, as Graham has said, which were needlessly subjected to a gastro-enterostomy for "medical ulcer," there being found at operation no demonstrable lesion in the stomach.\* In other cases, says Cheney, the history is that corresponding to hyperchlorhydria, with heartburn, water-brash, flatulence, and nausea, but without pain or vomiting. It seems probable that many of the cases of "sour stomach" resisting all forms of medical treatment are due to chronic appendicitis. In fact, this has already been proved in those cases in which the removal of a chronically diseased appendix has been followed by a relief of all symptoms and a return of the gastric secretions to normal. A third group of cases complains of heaviness and fullness after eating, flatulence, belching and regurgitation of food, an inability to take more than a small amount of food at a time. These cases may show a normal stomach analysis and the symptoms seem to be due to pylorospasm. The author has not always been able to get a history that points to the appendix as the seat of disease, but believes that the so-called "bellyaches" of childhood are very often due to appendix inflammation which lays the foundation for the future dyspepsia. Another important point in the diagnosis is that the epigastric pain and other gastric symptoms are either excited or increased by exertion. Again, the time of onset of the pain is usually irregular in contrast to the striking periodicity in gall-stones and ulcers. Unfortunately the occurrence of hematemesis, or blood in the stools, does not speak absolutely against the diagnosis of appendicitis; for evidence is accumulating, says Cheney, that the occurrence of hematemesis can no longer be considered as speaking for gastric ulcer in the differential diagnosis between the two.—*Med Rev. of Reviews.*)

THE TREATMENT OF FLOATING KIDNEY.—Professor Fürbringer (*Deut. med. Wochens.*, No. 18, 1911), points out that a fully developed movable kidney that does not give rise to symptoms will not require treatment, and such patients should be assured of the harmlessness of their condition. If the abdominal walls are flaccid some means of support, as bandages or a corset, should be employed and will be found sufficient in the majority of uncomplicated cases. They must, however, exert pressure upon the entire abdomen from below forward and from above backward, and lift up the kidney indirectly, that is, through the subjacent abdominal contents. Rest on the back relieves the frequently recurrent pains, but he has never seen any permanent restoration of the kidney to its normal condition through prolonged use of this method. Massage, if employed at all, should be very gentle. Operative fixation of the kidney in cases where this condition causes marked disturbance and interference with work gives excellent temporary results in a larger number of instances

although the end results are less promising and the procedure is not free from risk to life.—*American Practitioner and News*, II—II.

THE WASSERMANN REACTION AND ALCOHOL.—Drs. Craig and Nichol's note (*The Journal A. M. A.*, August 5), raises a very important practical point. The Wassermann reaction, though it has been found to occur in a few other diseases, has come to be pretty generally accepted as a practical test for syphilis, at least in this climate, and surpassing all others as a test for latent infection. If, however, we are to find it unreliable in case of alcoholics or, speaking more broadly, that its value is abolished by even moderate alcoholic ingestion, its practical use is seriously embarrassed. Most subjects of syphilis are at least occasional users of alcohol and if the test can only be accepted as of positive value when it can be definitely proven that they have not indulged in the use of alcohol for at least twenty-four hours or, still better, for two or three days before the test is made, then it will be only in hospitals or where the individuals can be kept under restraint that any positive conclusion as to the existence of syphilis can be obtained. A general public knowledge of this fact might vitiate all the Wassermann tests being made and this aspect of the matter is one worth considering.

NEW TREATMENT OF TUBERCULOSIS.—Dr. Leonard Robinson in the *British Medical Journal* describes Szendeffy's new treatment of tuberculosis with a basis of iodine and radium. According to Bernheim, radium is slowly eliminated in the lungs, thus exerting a bacteriacidal effect upon the tubercle bacillus.

It is claimed that the new compound has a decided influence on streptococci, is a general tonic, has a dynamogenic action, causes an increase in weight, persists in its beneficial action despite intercurrent disease, causes disappearance of tuberculous glands, favorably affects tuberculous laryngitis, diminishes the quantity of sputum, suppresses cough, fever, and night sweats, regulates the gastric functions, and improves appetite. The composition is given as follows: Peptonized iodine, gramme 0.75, menthol, gramme 0.06, radium barium chloride, quantity not given. It is administered intramuscularly in the gluteal region.

THE REFEREE BOARD ON SACCHARIN.—The publication of the detailed report of the investigations carried out by the Referee Board in response to questions raised by the Secretary of Agriculture bearing on saccharin and the public health affords numerous data of interest aside from the immediate purpose for which the work was planned. The main general conclusions reached by the scientific experts are summarized as follows:

"1. Saccharin in small quantities (0.3 gram per day or less) added to the food is without deleterious or poisonous action and is not injurious to the health of normal adults, so far as is ascertainable by available methods of study.

"2. Saccharin in large quantities (over 0.3 gram per day and especially above 1 gram daily) added to the food, if taken for considerable periods of time, especially after months, is liable to induce disturbances of digestion.

"3. The admixture of saccharin with food in small or large quantities has not been found to alter the quality or strength of the food. It is obvious, however, that the addition of saccharin to food as a substitute for cane-sugar or some other form of sugar must be regarded as a substitution involving a reduction of the food-value of the sweetened product and hence as a reduction in its quality."

The decision of the government, already referred to in these columns, to exclude saccharin from commercial use in foods must appeal to everyone as correct and inevitable; one might well question whether this elaborate research was necessary to furnish occasion to forbid the use of a substance which can find little justification for its introduction except on the grounds of deception or concealment of inferiority. No intelligent individual can have supposed that a few milligrams of saccharin are the nutritive equivalent of the sugar, the absence of which it conceals; and the therapeutic uses of saccharin can safely be left in the hands of the medical profession.

As a scientific contribution to the physiology of nutrition, however, this report is worthy of more than passing attention. The experimental work was conducted by the late Professor Herter of New York and Professor Folin of Boston. The "small dose" of saccharin adopted was up to 0.3 gram (5 grains) per day, while the "large dose" ranged from 0.75 gram to 1.5 grams daily. These amounts correspond in sweetening power to approximately from 5 ounces to 1½ pounds of cane-sugar per day. Several of the human subjects took saccharin almost uninterruptedly with every meal for a period of about five months.

We cannot refer here in detail to the many points of physiologic interest touched on in the report. It is clearly emphasized, however, that the vaunted preservative effects of saccharin are at best extremely small. Thus the last plausible justification for its employment is made to fade away. Fortunately the very character of the compound serves as an effective barrier against its being used in large amounts; for its taste, an extreme sweetness in dilute solution, merges quickly into an intense and persistent bitterness when the concentration is materially increased. The lethal dose for rabbits lies beyond 10 grams. This in itself would be no guarantee of any innocuousness of the continued use of saccharin, except for the fact that all which is absorbed from the intestinal tract is rather promptly eliminated and that there is no storage of the substance in the body. Saccharin appears to be excreted unchanged, and a possible cumulative effect of the drug is thus made unlikely. These facts are of great value in considering the safety with which saccharin can be used in its legitimate sphere, namely, as a substitute for sugar by patients suffering from diabetes, or in certain treatments for the reduction of obesity.

The disturbances which, though by no means of constant occurrence, are charged to the use of larger doses include serious distaste for the substance, modifications of gastric functions (increased free hydrochloric acid), changes in the reaction of the feces, and occasional increase in the putrefactive products (indol, skatol, hydrogen sulphid) in the stools. Otherwise the findings are what may be termed "negative."

The elaborate analytical tables, which could scarcely obtain publication without the cooperation of financial support such as the government freely



gives, incidentally bring renewed evidence of the validity of some of the well-known conclusions with respect to nitrogenous metabolism which were formulated several years ago by Professor Folin. The constancy of the creatinin elimination in man as an index of metabolism, and the relative variability of the output of urea and ammonia compounds in dependence on the exogenous, or diet factors are clearly shown. Such data, to mention only a few, will serve a useful purpose quite apart from the immediate purpose of the investigation. Considered especially as a physiologic research, this report is a credit to American investigations in human nutrition.—(*Jour. Amer. Med. Assoc.*)

**THE TREATMENT OF TUBERCULOUS PERITONITIS.**—Rolleston writing in the *British Medical Journal* of September 2, 1911, upon this topic says that treatment may be conveniently divided into (1) general hygienic treatment, (2) medicinal treatment, including diet, (3) treatment by vaccines, (4) x-rays, (5) surgical.

*Hygienic Treatment.*—The patient should be kept absolutely at rest in bed, and as far as possible in the fresh air and in the sun. When the disease has been arrested the patient's life should be regulated with the same care as in pulmonary tuberculosis.

*Medicinal Treatment.*—Drug treatment does not play an important part in the treatment. As iodine and its preparations appear to have special action on tuberculous processes, iodoform and syrup of the iodide of iron are not uncommonly used. Hypodermic injections of iodine with iodide of potassium and guaiacol have been recommended. It has been suggested that the iodine passes into the ascitic effusion and exerts a beneficial action there (Yeo), but according to Landolfi, iodides taken by the mouth do not appear in tuberculous effusions. For flatulence and diarrhea it is probably better to give guaiacol or one of its compounds, such as thiocol or styracol, than creosote, which may be irritating or even toxic. Salicylate of bismuth and salol may also be tried; opium by the mouth may be required for obstinate diarrhea. Opium by the mouth may be necessary for pain, but in older children the author prefers morphine hypodermically.

*Local Application.*—Formerly mercurial ointment rubbed into the abdomen by a bandage was generally employed, and is worth a trial. Iodine and iodoform may be supplied in the same way. In addition to the benefit derived from the absorption of mercury and iodoform, it is probable that the application of the bandage is important in insuring rest to the abdomen. Good results have indeed been obtained from simply strapping the abdomen (Knox), and it is conceivable that some of the benefit ascribed to simple laparotomy is due to the subsequent bandaging. The abdomen has also been kept at rest by painting on collodion with or without tincture of iodine.

*Diet.*—The diet should be nourishing and largely protein, to which cream and fatty food, including cod-liver oil, should be cautiously added. Starchy and vegetable food should be avoided, on account of their liability to cause flatulence. A salt-free diet has been recommended in order to diminish ascites (Alwens), but it is doubtful if there is any advantage, apart from the obvious desirability of preventing mechanical embarrass-

ment, in restricting the effusion; for the ascites may diminish as the patient goes down-hill and plastic peritonitis develops.

*Vaccine Treatment.*—Opinion on this form of treatment varies as much as it does on the question of operation. Wright recommended it, and Riviere and Latham have also obtained good results. Still, on the other hand, has given it by the mouth, hypodermically, and by the rectum, and in most instances without any effect. The author has given it in the small doses advocated by Latham in a number of cases, and in some with subsequent improvement; two cases which made much impression on his mind rapidly went down-hill after, though he asserts he cannot say because of, its use. The value of vaccine treatment in tuberculous peritonitis is put forward for discussion.

*X-rays*, which have been given a fair trial and which have been favorably reported on by some (Dodson, Urbino), do not appear to be of any real therapeutic value (Allaria and Rovere). Extension and generalization of the tuberculous process have followed this treatment, and as x-rays in excess induce leucopenia, it is obvious that the patient's resistance may be impaired.

*Surgical Treatment.*—In order to clear the ground it may be stated as generally agreed (1) that operation is contraindicated in generalized or wide-spread tuberculosis, and therefore in infants under twelve months of age and in patients with signs of pulmonary tuberculosis; (2) that it is unnecessary in the fibrous and adhesive forms in the absence of any urgent symptoms of intestinal obstruction; (3) that it is necessary in cases of abscess formation and in intestinal obstruction. It must be remembered that the last complication may be simulated by the onset of tuberculous meningitis. The question of operative interference therefore concerns cases of ascitic abdominal tuberculosis. The much debated question of operation may be introduced by a brief consideration of its mode of action. It has been supposed that operation reduces the feeble vitality of the peritoneal tubercles so that they undergo involution and death. More recently the explanation has been put forward that peritoneal tuberculosis being a local infection the opsonic index of the ascitic effusion is lower than that of the blood; hence after the removal of the ascites there occurs a fresh effusion which is of a higher opsonic index, and therefore has a curative action on the local tuberculous process (White). If this be true, simple paracentesis should be as effective as laparotomy. The advantage of laparotomy, however, over simple tapping is that a local focus of tuberculosis which may give rise to reinfection and relapse after partial or apparent cure may thus be detected and removed (W. Mayo). In this connection it is important to get some estimate of the frequency with which such a focus is present and can be removed. In Mayo's 26 cases in which the Fallopian tubes were removed, 25 recovered permanently, and in 7 of these simple laparotomy had previously been performed from one to four times for the cure of tuberculous peritonitis. On the other hand Stone, who holds a brief for the hygienic as opposed to the surgical treatment, in 122 cases of tuberculous peritonitis of all ages did not find a primary focus in the Fallopian tubes or appendix in any case. Undoubted primary tuberculosis of the Fallopian tubes, though common in women, is very rare in young girls; Murphy

quotes Maas as having, after a careful search, only been able to collect 8 cases. As was shown by Murphy's experiments on monkeys, the Fallopian tubes rapidly become infected secondarily in tuberculosis of the peritoneum. In 23 cases of generalized tuberculous peritonitis in female children, 9 showed tuberculous salpingitis (Still). According to Goodall, 99 per cent of the cases of tuberculosis of the fallopian tubes are secondary, though in from 30 to 50 per cent of these cases the primary focus is not obvious. But secondary infection of the fallopian tubes may give rise to very considerable enlargement, and the tuberculous focus thus produced, though not primary, may set up reinfection of the peritoneum and so require removal. In a girl aged nine the fallopian tubes infected secondarily to tuberculous peritonitis were the size of the index fingers of an adult, and were removed; ten years later she was in good health (Murphy). Removal of tuberculous glands may be very difficult, and an attempt to do so may leave the patient worse off than before. The argument in favor of laparotomy that a removable tuberculous focus may thus be found is on the whole valid, but not very strong.

It is generally agreed that the ascitic cases do well, whether they are operated upon or left alone. The following questions therefore arise: (1) Are the results better in the operative cases than in those which are treated medically? (2) As some cases begin as ascites and go on to the ulcerative or plastic stages, is there any reason to believe that early laparotomy will prevent this sequel? If so, operation would be justified. On these points statistics would be of value.

Although, as already mentioned, statistics on tuberculous peritonitis usually deal with all forms of the disease, it is desirable to quote some dealing solely with the disease in children. Faludi has drawn up tables showing the percentages of cures in parallel series of cases of tuberculous peritonitis in children, operated upon and not operated upon. The authors he quotes are Cassel, Monti, Pic, Schmitz, Schramm, and Sutherland, who all give parallel series of cases operated upon and not operated upon. The divergence in these statistics is considerable. Schramm found 80 per cent of cures among the operated cases and 64 per cent among the non-operated; Pic observed recovery in 74 per cent of the operated cases and in 5 per cent only of the non-operated; Sutherland observed recovery in 50 per cent of the operated cases and in 81 per cent of the non-operated. By adding up all the operated cases we get 88 cures, or 70.4 per cent, in 125 cases, as contrasted with 51 cures, or 33 per cent, in 156 cases not operated upon. The question of operation on ascitic cases may be fairly summed up in the statement that it should be tried after hygienic and medical treatment has been given a fair trial for a month or so without any definite benefit.

Simple paracentesis is not often necessary and is seldom practiced. After removal of some of the fluid, injections of various kinds through a cannula have been employed; thus sterilized air, oxygen (Schulze), isotonic salt solution, adrenalin (Wynter) have been reported to give good results. The injection of camphorated naphthol is a dangerous procedure (Guinard). The author states he has had no experience with any of these methods.—(*Therapeutic Gazette*).



THE TREATMENT OF PSORIASIS.—By A. W. Nelson, M. D.—My treatment is divided into general, internal, and local.

The *general* considerations are the following: Age of patient, season of the year, location and extent of surface involved, thickness of patch, of acute or chronic development, and whether it is in the involutionary or exacerbation period of the disease. Better results may be expected during warm weather and during the involutionary period of the disease.

Other diseases that may be associated should be removed. The patient should be placed in a good state of health by proper regulation of the diet, by rendering his surroundings as hygienic as possible, by advising suitable exercise, strict attention to cleanliness of the skin, and to the proper performance of intestinal function. The diet should be simple, nutritious, and mixed as the case may demand. In the acute inflammatory stage, a vegetarian diet, in the writer's opinion, is desirable. Alcoholic drinks should be forbidden.

If the general nutrition is reduced, good results may be expected from the elixir of iron, quinine, and strychnine phosphates. If the disease is associated with a gouty or rheumatic condition, a mixture of sodium salicylate and potassium iodide will prove beneficial. When the symptoms are of a marked inflammatory type, liquor potassæ, ten drops in a glass of water, three times daily, will serve well. Cases not presenting any of the features just described are treated as follows, unless contraindications are present.

*Internally.* Arsenic in some form. Liquor potassii arsenitis is the most convenient. While administering the arsenic we must not lose sight of the fact that excessive and prolonged administration of the drug may produce horny growths which are subject to epitheliomatous changes.

*Local treatment* depends upon location, extent of surface involved, thickness of patch, etc.

Before applying any remedy the epidermic scales of the patches are macerated and removed and the hyperæmic skin beneath is exposed. This may be accomplished by the following means:

1. If the patches are few and thin, immersion of the parts in warm water, and the use of a hand brush or rag, with soap, will suffice.
2. If the eruption is mild and generally disseminated, an ordinary daily bath for about twenty minutes may suffice. The action of the bath may be facilitated by the addition of six ounces of sodium bicarbonate or four ounces of ammonium chloride. If the skin becomes rough after bathing, a little cold cream may be applied.
3. If the patches are thick the baths are followed by an application of olive oil containing five per cent. of salicylic acid.
4. In cases not responding to any of the methods just described, dressings soaked in olive oil or liquid petrolatum are applied and enveloped with waxed paper between the baths.

After the lesions are freed from scales and none is on face or head, reducing or slightly irritating remedies give best results.

In classes one and two rub well into the patches once or twice daily the following: Chrysarobin and salicylic acid, of each one and a half gramme to three grammes; benzoated lard, enough to make thirty grammes.

In classes three and four rub well into the patches once or twice daily the full strength of the prescription.

If severe irritation is threatened, discontinue the chrysarobin and apply soothing remedies. When the patches become pale or whitish the application of the ointments is discontinued. If no improvement follows, an ointment of tar, two to ten per cent., is tried instead. In severe cases, the tar ointment may be increased to twenty-five or fifty per cent., rubbed in, the excess wiped off, and the skin dusted over with ordinary talcum powder. The tar ointment is applied to a limited surface at a time for fear of intoxication. While using the ointments the patient's clothes are protected. Occasionally, instead of prescribing an ointment, the painting of the patches in the milder cases with the following is resorted to: Salicylic acid, chrysarobin, of each three grammes, chloroform, enough to make thirty grammes. Paint, and when dry apply a layer of flexible collodion. While this mixture is more elegant, it is not as efficient as the ointment.

*For scalp.* First shampoo with liquor saponis mollis and apply an ointment containing from ten to fifteen per cent. of ammoniated mercury, and five to ten per cent. of salicylic acid. Shampoo often.

*For face.* It is first washed in warm water and a ten per cent. white precipitate ointment or a ten to fifteen per cent. ointment of beta naphthol in white petrolatum is advised.

*For nails.* Have nail short, scrape rough surface, and bathe in warm water. If the horny layer is too thick, apply a one per cent. of liquor potassæ on a pledget of cotton until the crusts are softened, and follow up with the ointment as recommended for the scalp. In some cases the wearing of a rubber finger cot will suffice to macerate and soften the horny layer.

Good results in the treatment of psoriasis may at times be achieved by the local application of high frequency currents, Finsen rays, of cupric electrolysis, and of Röntgen rays; the relative value of these agents being in the order named.—*N. Y. Med. Jour.*

OCULAR COMPLICATIONS OF ACUTE EXANTHEMATA.—In small-pox the cornea is attacked in from 38 per cent. to 70 per cent. of cases, in which the eyes suffer. Before the advent of vaccination about one-third of all cases of blindness were caused by small-pox, but vaccination has reduced this to about 5 per cent. The lid complications are secondary to the ulceration following pustules. Iritis and choroiditis have been observed. Vaccine may be associated with phlyctenular disease of the conjunctiva, but this is of no importance. The accidental inoculation of an eye with vaccine, may, however, be serious. Vaccine ulcers of the lids and conjunctiva are not uncommon; corneal ulcers may be severe and dangerous. Measles. In this disease acute catarrhal conjunctivitis is the symptom: It may take on a pseudo-membranous form.

Streptococcal infection is most dangerous and may end in rapid sloughing of the cornea. Apart from their association with conjunctivitis, corneal ulcers are rarely seen in measles.

Trautas (Constantinople) describes a superficial punctate keratitis, which he says is present in 75 per cent. of all cases; in fact, Trautas is inclined

to regard it as rather a pathognomonic sign than a complication of measles. The keratitis begins on the third, fourth or fifth day of the malady and takes the form of a slight cloudiness of the cornea with numerous superficial whitish spots visible with a loupe. This usually affects both eyes and may not be associated with any symptom of irritation.

*Scarlet Fever.*—The most important ocular complication is amaurosis. Sudden blindness may appear without any external or ophthalmoscopic signs except slight dilatation of the pupil. Convulsions are often present. Albuminuric retinitis is rare.—Dr. Griscum, *Brit. Med. Jour.*

WILLIAM SPENCER, M. D.

RESULTS OF TREATMENT OF LACRIMAL OBSTRUCTION BY DRAINAGE WITH SKEINS OF THREAD.—The author says that although Bowman's method marked an immense progress in the treatment of lachrimation, it has its dangers and is very unpleasant for the patient, nor is it invariably successful. The use of the style was an advance in the treatment, but it acts as a foreign body, irritating the eye. A modification of this method is the introduction of a pliable drain into the passage, either from above downward or from below upward, which has been in use in France for some time. The author describes his method. He first passes a hollow canula about the size of a No. 4 Bowman probe, through which passes a very delicate, flexible bougie armed at the end with a silver knob of the diameter of the canula; with appropriate instrument this knob is pulled out as far as the external nares. A drain composed of several loops of silk impregnated with iodoform, with extra superior and inferior loops, is drawn upwards into the lacrimal sac, but not as far as the superior canaliculus, the upper loop only making its exit, and being severed from the bougie. The inferior loop is placed in the nares. Daily lavage of the drain by injection into the lacrimal sac is necessary. The first drain consists of 6 to 8 threads, and should be kept in situ for several days. Then it should be replaced by one of 10 to 12 and so on up to as high as 24. In this way a gradual painless dilatation of the passage is accomplished, while drainage is going on. He claims that this method is of advantage in cases where other forms of treatment have failed. When there is a stricture, in young children, and where a narcosis would be necessary otherwise.—Dr. F. Ostwalt, *Archives d' Ophthalmal.*

WILLIAM SPENCER, M. D.

THE EFFECT OF MEDICATED VAGINAL DOUCHES UPON THE NORMAL AND PATHOLOGICAL (NOT PUERPERAL) VAGINAL FLORA.—Polano has examined the effect of solutions usually employed for vaginal douches upon the bacteria in the vagina. His results show that a great diminution in number up to complete absence of bacteria may be obtained by the use of alum 2 per cent. alcohol 4 per cent, salol 2 per cent, argentum nitricum 0.2 per cent, iodine 9.2 per cent, irrigation with unboiled water, and the dry treatment with bolus alba. Lysoform 1 per cent, has no effect. On the other hand, an enormous increase in the number of bacteria was found after acetic acid 2 per cent, lysol 1 per cent, lactic acid 2 per cent, soda 2 per cent. It is accordingly not so much the bactericidal as the mechanical cleansing action of the solutions which is effective.—*Zentralbl. f. Gyn.* 1911, 961.

THEODORE J. GRAMM, M. D.



PLACENTA PRAEVIA.—Schweitzer (Leipzig) in reporting 100 cases considers the various means employed in the treatment. Of the combined version according to Braxton Hicks he says that for the mother this is the best method provided after the version extraction is not made, for cervical lacerations must be avoided as dangerous. The combined version comprises but one manipulation and does not cause hemorrhage. For the children the prognosis is less favorable, the total mortality having been 68 per cent, and 64 per cent, for those which were viable. The combined version is therefore best indicated with dead fetus or non-viable child and in weakened conditions of the mother.

Metreuxy, especially intraamniotic, is much more favorable for the children. Total infant mortality 12 per cent, and 6 per cent, in viable children. For the mother this method is much more of an intervention; it requires usually two manipulations, the introduction of the balloon and later the delivering operation, which may be version and extraction. The hemorrhage is much more profuse (680 cm.) and therefore rather risky in weakened conditions of the mother. So that this method is advisable in the interests of the child and only when the condition of the mother is good. A certain amount of operative skill is required and the operator must remain with the patient. For this reason, the author says, it is not to be preferred to version.—*Zentralbl. f. Gyn.* 1911, 928.

THEODORE J. GRAMM, M. D.

MEDICATED TAMPONS IN GYNECOLOGY.—According to Schwab (Nurnberg) the effect of medicated tampons depends alone upon suggestion and patients believe that the gradual improvement, setting in of itself, depends upon their use. In fact, however, the absorptive power of the vaginal mucous membrane is so slight that a medicinal action is not to be thought of. The less so since the solution used, namely glycerine, instead of favoring absorption caused rather an increased excretion. At best a certain advantage is obtained from sufficiently large tampons protecting inflamed organs against painful motions of the body.—*Zentralbl. f. Gyn.* 1911, 886.

THEODORE J. GRAMM, M. D.

CANCER OF THE UTERUS AND EARLY OPERATIONS.—Ulesco-Stroganowa (St. Petersburg) has reported three cases of inflammatory processes on the cervix in which an excised fragment for microscopic examination showed pictures of malignant degeneration, namely atypical proliferations of cells, hyperchromatosis and numerous mitoses, in whom, after treatment of the inflammatory condition while waiting for operation thereby presumptively effecting the removal of irritation, the specimen obtained at the operation showed a distinct improvement of the condition regarded as pointing to malignancy. The illustrations seem to confirm the statements in the text. From these observations the conclusions are reached that a typical epithelial proliferations of even such high grade that pictures of malignant hyperplasia were presented, do not warrant the diagnosis of cancer and extirpation of the uterus, if there also exists another distinctly developed process like gonorrhœa, tuberculosis etc. These alone are able to cause and maintain such atypical proliferations. It is more correct to treat such patients so as to remove the underlying disease which

probably caused the atypical proliferation. In the first two cases there was the erosion, and in the third case gonorrhœa. After a certain time another piece may be excised or the cervix may be amputated which may then be carefully examined in order to accurately determine the nature of the process.—*Zentralbl. f. Gyn.* 1911, 770.

THEODORE J. GRAMM, M. D.

THE TREATMENT OF PURULENT PERITONITIS WITH CAMPHORATED OIL.—In nine apparently fatal cases Hirschel opened the abdomen and removed the pus, after the site of perforation had been treated as required. Then from 3 to 10 ounces of warmed and sterilized 1 per cent, camphorated oil was spread in the abdominal cavity. No harm resulted to the patients, but on the contrary they were all very materially benefitted. The pulse, almost imperceptible before operation, improved greatly, the intestinal paralysis disappeared, and the vomiting ceased. Five of the patients recovered. The author believes with Höhne that the reactive inflammation of the peritoneum has much to do with the favorable results although occlusion of the lymphatics and the enveloping and rendering harmless of the bacteria by the oil may contribute. The author believes that the treatment should be further tried.—*Zentralbl. f. Gyn.* 1911-800.

Krecke (Munich) treated eleven cases in the same manner, of which five were due to perforation of a gangrenous appendix. All the patients were saved. Schläfli also refers to 53 cases similarly treated, among whom only one was lost.

Burkhardt also says that mice injected with camphorated oil were not injured by intraabdominal inoculation with streptococcus bouillon, while the control animals all died.—*Zentralbl. f. Gyn.* 1911, 793.

THEODORE J. GRAMM, M. D.

THYROID EXTRACTS AND ENURESIS.—“Dr. Leonard Williams, physician to the French Hospital, contributes to the *Lancet* of May 1st, an interesting case of a boy, aged 9, a pupil at Christ's Hospital, who was suffering from nocturnal enuresis. He had been circumcised while a baby, so that phimosis could be excluded as a cause. Some adenoids were present and they were removed, with the effect of considerably aggravating the incontinence. Thinking that the removal of the adenoids might have deprived the patient of some internal secretions, which up to that time had partially protected him against enuresis, he decided to try the effect of thyroid extract. He was led to employ this substance from what seems to us the inconclusive reason that the thyroid gland has very intimate relations with the lymph glands, and that adenoids consist of lymph tissue. The boy was spare, bright, and intelligent, but two inches shorter than the average for his age. He began by taking half a grain of thyroid extract night and morning. The enuresis immediately ceased, and under the influence of the thyroid treatment never recurred. Six days after treatment had commenced he had gained over five pounds in weight and in a fortnight had gained seven pounds and reached the average for his age.”—*Brit. Homoeop. Rev.*

American Institute of Homoeopathy,—Next Meeting at Pittsburgh, Pa., June 16th to 22d, 1912.

## Monthly Retrospect

### OF HOMOEOPATHIC MATERIA MEDICA AND THERAPEUTICS

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CONDUCTED BY A. LEIGHT MONROE,

Miami, Florida.

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ACETANILIDE POISONING.—The following is a summary of a typical case of *acetanilide* poisoning, reported by Dr. H. C. Gordinier, in *Boston Medical and Surgical Journal*, August. The patient was a woman of thirty, who first denied any drug habit, but afterwards admitted being a heavy user of acetanilide. "She complained of great weakness, palpitation, faint attacks, and shortness of breath. There was a striking cyanotic tinge of the lips, ears, fingers, and toes. The conjunctivæ were pale and cyanosed, and the skin of the whole body was bluish-black. This coloration varied from time to time, its periods of greatest intensity coinciding with an increase of the subjective symptoms. The heart was dilated, and there was a murmur of mitral incompetence. The spleen was enlarged and tender, the liver less so. An examination of the blood, at first interview, discovered an erythrocyte count of 9,200,000 per cubic millimetre, with some poikilocytosis, but no other striking change. Several years later, however, the count had fallen to 2,142,610 per cubic millimetre. The color of the blood was bluish-black. There were several points of superficial ulceration in the skin, one on the front of the left leg, another on the pinna of the ear, and a third in association with the scar of an abdominal operation. A very careful examination of the urine was made. The specific gravity was 1026; the color, brownish-red when it was passed, changing later to an inky black. It reduced Fehling's solution and yielded dextrosazone crystals with the phenylhydrazine test. The ethereal sulphates were greatly increased. There were no blood pigments, the abnormal color being due to urobilin. Glycuronates were probably, but not certainly, present. A rapid and continuous improvement began as soon as the tablets were stopped. After a period of excitement and sleeplessness the patient lost her craving for the drug and was apparently cured. The second patient was also a woman, 52 years of age. In her case there was a varying cyanosis, and both liver and spleen were tender and enlarged. The blood and urine displayed much the same changes as in the first case, and there was a similar cardiac enlargement. From his study of these cases and those recorded in medical literature, Dr. Gordinier concludes that the continuous ingestion of acetanilide or allied products creates a perfectly definite syndrome of cyanosis, with enlargement of heart, spleen, and liver, a definite blood picture and characteristic urinary findings; and that there is an equally definite acetanilide habit.



This, from the *Lancet*, forms a good basis for a proving of acetanilide, such provings as Hahnemann used freely when he worked up his great *Materia Medica*, which will outlive all the medical books current to-day.—*Homœopathic Record*.

"IS CHINA OFFICINALIS A PROPHYLACTIC IN GALLSTONE COLIC?"—This was the title of the paper by H. E. Beebe, of Sidney, O. He stated that in 1843 Dr. David Thayer, of Boston, was haled before the medical society and expelled for heresy for asserting that a dilution (potency) of china would cure gall-stone colic. Dr. Beebe, in his paper, says:

"China will not cure gall-stone colic, but I firmly believe from long clinical experience that it will often, yes very often, cure the cause of chronic cholelithiasis, thereby the attacks of colic disease. It is not claimed that the stones already formed are dissolved, but it will prevent the formation of new stones.

"The action of china upon the liver changes an abnormal secretion to a normal state, thereby overcoming the condition predisposing to the formation of biliary calculus. Some contend that gall-stones are most often prevalent with those who use quinine habitually, but as to this I do not know.

"Consult any homœopathic materia medica from Hahnemann down and you will see recorded under china provings and verified clinical symptoms similar and very similar to those found during or after gall-stone colic. None claim that china will produce genuine colic, although we have seen the alkaloid, quinine, produce the most severe colic.

"By removing the original cause, the prevention of future attacks, first by lengthening the intervals is brought about, although I have frequently seen patients where there never was another attack of colic. You may say this was merely a coincidence. No, these coincidences are most common.

"My method is to give my patient china in pellets the third dilution four times a day for two weeks, after which lengthen the interval to three times and finally twice and once a day. This treatment should be continued for one or two years.

"I restored to the olive oil and phosphate of soda treatment for a time and must say both are of some value, but finally I returned to my first love, China, feeling satisfied that it is superior to the other treatment."

Dr. C. A. Schulze, agreeing with Dr. Beebe said, among other things:

"In regard to the after treatment, I believe that the essayist and others would have better results if they were to give china high. He speaks of giving it in the third potency for a long while. Experience teaches that if you alternate the potency you get better results. Very frequently in those cases if you alternate a third and a thirtieth, or a twelfth and a thirtieth or a thirtieth and a two-hundredths you get better results. One seems to boost and the other seems to shove, and helps along a great deal better. I believe that in the latter state of treatment, by giving the remedy high at infrequent intervals, you will get better results, anywhere from two-hundredth up as high as you care to go. I can only sanction, however, what the essayist has said in regard to the use of china officinalis in gall stones."

**THE TONSIL QUESTION.**—"Tydings, of Chicago, is credited with having performed, ten years ago, the first tonsil enucleation done in this country and, as we are still practically the only country on earth doing such enucleation, he is probably to be credited with the first scientific tonsillectomy ever done. It appears that but few men followed Tydings' lead, for between 1900 and 1904 there is little in tonsil literature to indicate that much general interest was taken in the subject."

Dr. Quay, Cleveland, said:

"It is claimed by many pathologists that after the age of about sixteen years the tonsils have no physiological value, so far as being essential to the health of the individual they are apt to be the seat of disease, or an avenue for general infection."

A. B. Schneider, Cleveland, said:

"There is a great deal of indiscriminate removal of tonsils, particularly in cities where school inspection has been established, and where inexperienced examiners recommend for treatment all cases that show even the slightest enlargement of the tonsils."

There is room for comment here, on the wholesale "examination" of children by the "inexperienced"—but what's the use?

Some years ago there was a modest little book, by Dr. J. Compton Burnett, published, entitled "Enlarged Tonsils Cured by Medicine." It received no especial attention from publishers or critics, but there seemed to be a quiet interest in the subject. The edition was sold out and another printed—with no changes, as the author has gone over to the other side. We mention this for the benefit of those who may occasionally run across those who object to operations.

**SULPHUR.**—After a case of gonorrhœa has been "cured" give a few doses of sulphur. If the case is not genuinely cured the discharge is very apt to return. The same may be said of hepar sulphur. Some physicians have so much confidence in this action of hepar that they always give it to their apparently cured cases of gonorrhœa to determine if their treatment has really been permanent;—a therapeutic test.

**IODIUM.**—Dr. W. B. Hinsdale, of Ann Arbor, has had considerable success in the treatment of exophthalmic goitre with Iodium. Several severe and chronic cases have been relieved, if not cured. Different potencies were used, but the 1x seemed to give the best results.

**BISMUTH.**—Pressure and nausea in stomach worse after eating. The pressure is followed by burning. Eructations of gas worse after drinking. Pain is severe, extending backwards to the spine. The gastric symptoms are better after drinking cold water, but are only temporarily relieved, after which the pain, nausea, and distress return more violently than ever. The tongue is thickly coated white, and the stools are of a liquid nature.

**SECALE CORNUTUM.**—Hæmorrhage of the stomach has been cured with secale, the dose being 15 drops of the tincture every two hours. The cases were characterized by blueness of the fingers and lips, and the patients wanting to be uncovered.

**ERIGERON.**—This remedy has been of service in gastric hemorrhage. There is violent retching, and intense burning in the stomach. The blood is red and increased by every motion. The oil of erigeron is the best form in which to use the remedy. One drop may be placed on sugar and given at frequent intervals.

Erigeron is also of great use in the treatment of nose bleed. In this condition the remedy may be applied locally as well as given internally.

#### REMEDIES IN DISEASES OF THE HEART:

**Spigelia.**—Undulating motion of heart. Indistinct beats running into one another. Tumultuous beating in any position. The heart beats are not synchronous with the radial pulse. With all conditions there are usually severe, sharp, darting pains, frequently shooting to neck, shoulder and left arm from the præcordia. Upon palpation a kind of purring fremitus may be felt sometimes. Patient is unable to move, even use of arms and hands produce aggravation. Audible beatings are common. Spasm of chest, dyspnoea and dry cough are produced by changing position. Patient is unable to lie down, or must be propped up upon right side. In rheumatic involvement of the heart Spigelia should be compared with Aconite. In heart affections complicating pleurisy compare Bryonia.—*W. B. Hinsdale in Jan. Century.*

**Kalmia.**—Heart's action very tumultuous, rapid and visible with hypertrophy and insufficient, especially if accompanied with rheumatoid pains or a history of wandering pains through the body. Like many other remedies the pains shoot down the left arm, which pain is a very usual one in cardiac affections as well as with drugs. Many remedies have such a pain, which is sufficient to call attention to the fact that "pains down the left arm" are not "keynotes." Kalmia has considerable reputation in heart affections associated with rheumatoid pains. In cases of chronic or subacute rheumatism with shooting pains down the left arm with slow, weak, irregular pulse and faintness, it has its sphere. Shooting pains down the left arm are common to cardiac affections and to several drugs. Many drugs have it. The symptomatic value of this symptom is not great.—*W. B. Hinsdale, in Jan Century.*

**Cactus.**—Cactus is probably as much abused by Homœopathists as is digitalis by allopaths. It certainly has very great energy and should not be displayed except upon clear indications and modified in size and frequency of dosage as the case progresses. Severe aggravations have repeatedly arisen from the third dilution. Indications: Difficult breathing, suffocating and fainting. Cold perspiration may come on the face, and the pulse during "sinking spells" lost for a time. Unless there is pain it will seldom be indicated. The pains are severe, shooting from præcordia through left shoulder to finger tips. Palpitation, arhythmyeal or rapid pulse, whichever it be, made worse by beginning motion. The type of pain is a "sensation as if the heart were being held in the grasp of a hand." The hand may alternately contract and close. Dr. Royal makes the following statement: "In two well marked cases, at least, it was useful when the symptoms calling for it had been produced by over-dosing a heart already affected." \* \* \* "In all cases requiring Cactus I have found the characteristic symptom, constriction as if by an iron band, among such



symptoms as cold sweat, violent palpitation, attacks of suffocation and inability to lie down."—*Jan. Century*.

**OXALIC ACID.**—Pain in the upper part of the abdomen and region of navel, coming on two hours after eating, with much flatulence and bitter and sour eructation, worse at night; patient is aroused about 3.00 a. m. Also burning sensation from throat down. Give the sixth trituration an hour after meals.

**ERIODICTYON (YERBA SANTA).**—In bronchitis, pharyngeal catarrh, constant hawking, pressure under sternum as of a heavy weight, necessitating a deep breath at times. Sharp pain in right lung. Cough is irritating and attended with expectoration of glairy mucus. Use mother tincture, drop doses.

**GRINDELIA.**—The cough is at first dry and wheezing, without expectoration and asthmatic. Patient fears going to sleep on account of loss of breath which awakens him.

**THE EXPLOSION OF THE URIC ACID THEORY.**—Observant and analytical physicians have long ago become sceptical as to the reality of any uric acid diathesis, which has for so many years served as a scapegoat for the dietary indiscretions of so many patients. Dr. E. Faber, a Danish physician, reviews and knocks down the whole theory. He says that the whole apparently harmonious and imposing structure when considered closer is seen to be based on premises which are either highly improbable or unproved. The physiologic bases are hollow or have long since crumbled away; the most important connections are missing and the steeple on the building—the treatment—rests for the most part on the empty air. Faber reviews the pathogenesis, the clinical experiences and symptomatology of the various affections which are grouped as manifestations of the uric acid diathesis, and shows how they all have one common causal factor which bridges the gap between them all, and which does not need the assumption of any diathesis to explain the true inwardness of the various affections. This one common factor is immoderation in eating. The conditions leading to overeating and drinking being usually the same for the members of a family, it is no wonder that the assumed "uric acid diathesis" affects all the members of the family, thus explaining its familial and inheritable character. The injury from overeating is felt most severely in different organs in different individuals. This explains the "mysterious" alternation of affections in the different members of the family, as for instance Charcot's classical example of a family in which the father has diabetes with obesity and of his five sons, three had gout, one diabetes, obesity and a joint disease, one obesity, and a daughter and granddaughter gout and obesity. The anomaly in the nuclein metabolism which is found in true uric acid arthritis—the low endogenous elimination of uric acid with the periodic increase and the increased elimination of exogenous uric acid—is not encountered in the other affections which are included in the alleged uric acid diathesis. This conception often stands in the way of rational management of the

case. With kidney calculi, for instance, alkalines are indicated while they are useless or do harm in uric acid arthritis. In the arthritis a purin-free diet is often indicated, but this is an absolute blunder in the chronic anemia and debility of chronic polyarthritis or for asthenic patients with myalgia and neuralgia. The assumption of the uric acid diathesis often blinds the eyes of the physician to the necessity of seeking a psychic cause for disturbances, which may be the only key to proper treatment. On the other hand, it is easier to incriminate the uric acid than to convince a patient that he is eating too much, but a radical cure or material improvement is possible only after a suitable anti-obesity or weaning course of dieting.—(*Med. Rev. of Reviews*).

**INJURIES OF THE ABDOMEN.**—Richard V. Hippel (*Zeit. für Versich.*) continues his consideration of this subject. He says that the stereotyped description of dullness in the right flank as due to injuries of the liver and of that in the left flank as due to injuries of the spleen is not at all applicable to all cases. The dullness due to the blood effusion may be found anywhere, according to the various positions of the body assumed after injury. Liver dullness at first is unchanged; soon after injury it may be increased because of the collection of blood near the liver, later it may diminish because of the developing meteorism or dislocation of the liver itself. With the development of peritonitis liver dullness progressively diminishes. The same signs may accompany injuries of the spleen. Fortunately, however, it is not important to decide which organ is the seat of injury and hemorrhage, for an abdominal section is indicated in any case. Surgeons, too, should not be so inclined to wait until the symptoms of shock have entirely subsided. Shock will usually disappear with the cessation of hemorrhage, and frequently this stilling of hemorrhage can only follow an operation.

Injuries of the stomach usually give signs of free air in the peritoneal cavity and a metallic percussion note or simple hyperresonance, changing in site with change in position of the patient, should be diligently sought for. Circumscribed dullness, if found, should be immediately marked out on the abdominal wall; it may be due to an exudate and the increase in size may clinch the diagnosis. Larger area of dullness usually means perforation of the small intestine with the infection of the peritoneal cavity by a considerable quantity of fecal material. Of course, none of these signs may be present in any given case. If, a short time after injury, the pulse is quickened, tenderness and reflex spasm of the abdominal muscles have appeared, there is spontaneous pain on deep inspiration, and the patient has become somewhat restless, injury of the intestines must be suspected, if there are no signs of extensive internal hemorrhage.

Ruptures of the urinary bladder are usually accompanied by fractures of the pelvis. Direct injury may rupture an overfilled bladder and this usually happens in drunkards. Vesical tenesmus, ineffectual or resulting only in the appearance of a few drops of blood at the meatus, is a very frequent symptom. Catheterization usually confirms the diagnosis: the difficulty is in deciding whether extraperitoneal or intraperitoneal rupture has taken place. V. Hippel closes his lengthy paper with the urgent

advice to send all patients in whom an intraabdominal injury is suspected to a hospital, so that immediate operation may be performed if the suspicions are confirmed by further study of the symptoms.—(*Charlotte Med. Jour.*).

APOCYNUM CANNABIMUM AN ANTIDOTE TO ALCOHOLIC POISONING.—“Twenty drops of apocynum cannabium decoction in a tumbler of water will put an ‘old soak’ on his feet quicker than any other remedy.” (“Elements of Homœopathy,” Boericke and Anshutz.)

This was my introduction to the use of this remedy in alcoholism, and my results with it have been gratifying to the extreme. Lately I have given larger doses than recommended above.

When I first see a patient suffering from acute alcoholic poisoning, I give him a teaspoonful of the decoction in a glass of water. Then I put three teaspoonfuls in a glass of water, and order two teaspoonfuls of this mixture to be given every half hour until I make my next visit. I repeat the teaspoonful dose in from six to twelve hours if necessary. I diminish the quantity of alcohol at the beginning of the treatment, mixing liquid peptonoids and water with the whiskey. In this way I am able to satisfy the craving and diminish the quantity of alcohol more rapidly than when whiskey alone is given. The liquid peptonoids act as a food also. Of course, the patient must never know of this substitution, and I have fooled some of the wisest and most experienced toppers in New York.

Briefly, the results are these: Patients who formerly took from three weeks to as many months on each spree, now are brought around in a few days. Apocynum also seems to stop the physical craving. If any craving does exist after the patient has sobered up I give teaspoonful doses of the decoction in a glass of water from two to four times a day until no desire remains. About a dozen cases so treated is my clinical record.

What is the *modus operandi* of apocynum in this condition? Simply antidotal. It is a chemical antidote to alcohol as well as a physiological. This is proven by the fact that the decoction is much more efficient than the tincture, and dilutions run in alcohol are of no value.

I believe that the action of an antidote to the primary effects of a poison is in perfect accord with the homœopathic law. (See “Physiological Antidotes and the Homœopathic Law,” read before the International Hahnemannian Society, June, 1907. Homœopathic Recorder, November, 1907.)—*Chironian*.

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Homœopathic Medical Society of the State of Pennsylvania,—Annual Meeting for 1912 at Delaware Water Gap, September 17, 18 and 19.

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American Institute of Homœopathy,—Next Meeting at Pittsburg, Pa., June 16th to 22d, 1912.



# THE HAHNEMANNIAN MONTHLY.

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MARCH, 1912

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## THE EFFECTS OF VASCULAR DISEASES UPON THE NERVOUS SYSTEM.

BY

CHARLES LEE BAILEY, M. D., ALBANY, NEW YORK.

(Read before the New York State Homoeopathic Medical Society, Feb., 1912.)

THE vascular diseases which concern the neurologist are arterio-sclerosis, atheroma and vaso-motor disturbances.

The overgrowth of connective tissue followed by calcareous deposits in the coats of the blood vessels, especially the intima, decrease the caliber and contractility of the blood vessels, thereby cutting off normal blood supply and reducing nutrition of the tissues. Normally, the intima presents a smooth surface, but when atheromatous changes occur, it presents localized areas of thickening and induration. The lesions of the intima weaken the media and adventitia, the thickened intima undergoes softening, rapid dilatation of blood vessels is likely to occur, and the muscular and elastic fibres totally disappear, the loss of their elasticity rendering them more liable to rupture, thus increasing our cases of apoplexy.

Alcoholism, syphilis, gout and chronic nephritis are the direct causes of undue wear and tear on our blood vessels. In elderly people, atheroma is often physiological and characterizes the natural involutional period of life.

Anders says: "Heredity may play no inconspicuous part in arterio-sclerosis, dependent upon the age. This fact furnishes to some extent, at least, the reason why senile changes in arteries occur at a much earlier period of life in some persons."

The nervous symptoms of arterio-sclerosis and atheroma are

headache, tinnitus aurium, vertigo, syncopal attacks and localized palsies, increased arterial pressure, marked accentuation of the aortic second sound and left ventricular hypertrophy.

Arterio-sclerosis may exist for years without growing apparent, especially if the deep vessels have become sclerosed. In every case of vertigo occurring in a person over thirty-five years of age, the radial, temporal, femoral and brachial arteries should be carefully palpated. The walls of the affected vessels are hard, the pulse owing to increase of tension is incompressible and in some cases the pulse wave will not be detected by palpation.

When doubt arises as to whether or not sclerosis exists, the pulse should be carefully palpated by means of two fingers. While compression is made with the index finger, if the middle finger detects a pulse wave arterio-sclerosis is present.

Vaso-motor disturbances are usually indicated by a localized edema of the skin or mucous membrane occurring in a nervous person. Its supposed cause is due to a venous stasis or to some pathological influence on the lymph channels, causing them to exudate a fluid. As yet no definite pathology is known. Symptoms of vaso-motor disturbances usually appear suddenly, the skin over the affected area is slightly elevated and reddened, paraesthetic disturbances such as numbness and tingling which is most common on back of hands, legs and sides of face, appear. Occasionally they appear on mucous membrane of lips, tongue or glottis. When occurring on the glottis dyspnoea may be produced to an extent to cause death.

In Reynaud's disease we have a form of vaso-motor disturbance which affects, symmetrically, parts of the body, especially the tips of extremities, such as the fingers and toes. This disturbance has been termed symmetrical gangrene.

The effects of vascular lesions on the system are interference with its nutrition, its blood supply being cut off and its tissues failing to receive proper nutriment; metabolism is greatly engendered and toxic materials which could otherwise be carried away accumulate and irritate nerve centers and cells. Perverted nerve function is the result.

Effects of vascular diseases upon the nervous system are interference with its nutrition, toxaemia and disturbances of metabolism.

**CARBON-DIOXIDE—A COMPARATIVE STUDY WITH REFERENCE TO  
OTHER CHEMICAL SUBSTANCES USED IN THE TREATMENT  
OF CUTANEOUS NEOPLASMS.**

BY

RALPH BERNSTEIN, M. D., PHILADELPHIA.

Clinical Instructor in Skin Diseases, Hahnemann Medical College, Philadelphia, Pa.; Consulting Dermatologist to the Women's Southern Homoeopathic Hospital, Philadelphia, Pa.; Consulting Dermatologist to the J. Lewis Crozer Hospital and Home for Incurables, Chester, Pa.; Consulting Dermatologist to the House of Detention for Juveniles, Philadelphia, Pa.; Dermatologist to the West Philadelphia General Homoeopathic Hospital and Dispensary; Dermatologist to Hahnemann Hospital Dispensary, Philadelphia, Pa., Etc.

THAT we have in solidified carbon-dioxide the remedial substance par excellence in the treatment of cutaneous neoplasms, both benign and malignant, cannot now be denied, and which from clinical evidence, because of its superiority will assuredly always take the place of the many chemical substances in common usage.

Drs. Pusey, of Chicago; Gottheil, of New York; Grindon, of St. Louis; Schalek, of Omaha; Beck, of Chicago; Lowe, of Edinburgh; Morton, Sutton, Zeisler, Fitzpatrick, Zweig, and a host of others who have investigated the uses of carbon-dioxide in the treatment of cutaneous neoplasms are practically unanimous in their opinions as to the efficacy of the freezing method of successfully treating the same.

In the comparative study to follow, the author is desirous of showing the marked superiority of the carbon-dioxide method of successfully treating cutaneous neoplasms in comparison with chemical substances, in combination and alone, which have been used from time to time.

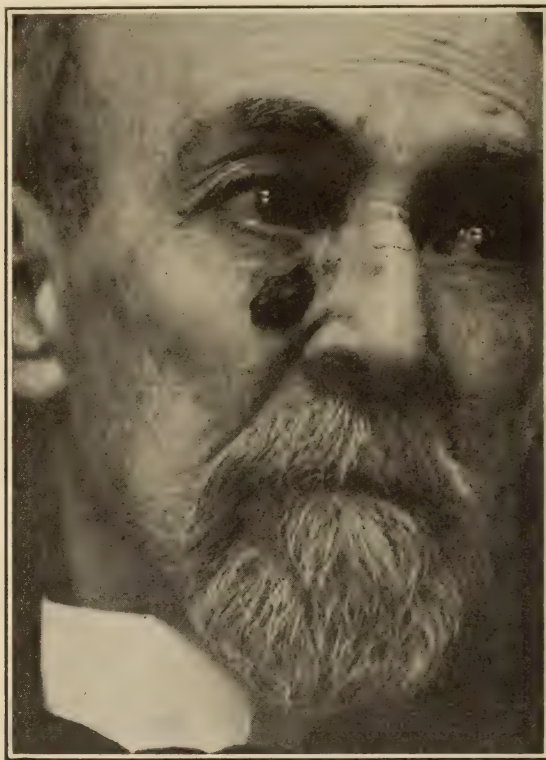
Perhaps in this comparative study it would be wise to begin with the more recent substances which are being advocated for the treatment of similar conditions for which carbon-dioxide is now practically admitted to be the choice of election in the treatment of hosts of dermatologic conditions which are amenable to its influence.

Probably the latest substance is a combination of radio-active thorium with didymium and lead salts, sulphuric acid and small quantities of hydrochloric and nitric acids, known as "Thoremadin," and advocated by C. B. Semerak, of Paris.



The American authorities who advocate its merits are Bulkley, Dearborn and Withington, of New York.

Bulkley, in one of his lectures before the New York Skin and Cancer Hospital, states: "I cannot now take time to consider just in what the therapeutic power of this product resides, that is, whether in the action of the acid, or in the so-



No. 1.—Concrete form of senile epithelioma; removal of concrete scab which held tenaciously; showing numerous dippings down of villi into the gaping follicular orifices. Before treatment.

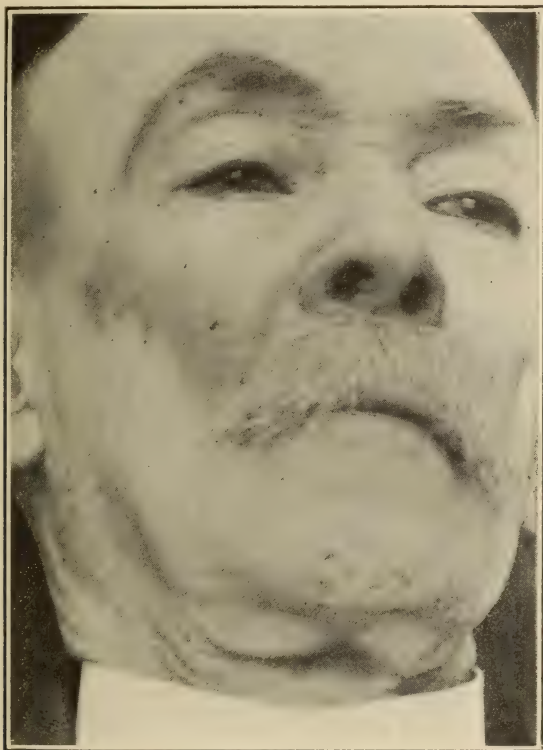
called radio-active substances, or in the combination of these two."

A.—Of a series of cases treated with this combination by the Skin and Cancer Hospital of New York the following number were reported cured—46, the number improved—2, partly cured—2, improved—24, still under treatment—17.

Thus, it will be seen that, from the number treated, a report of cure is made in about fifty per cent. This range of cases

treated covers almost the entire category of cutaneous neoplasms.

B.—In a report of 47 cases treated, from the Flower and Metropolitan Hospitals of New York and from private practice, 13 of which were still under observation, 19 of which were epitheliomas, 6 of which were reported cured and 10 much relieved, making a percentage of practically one-third cured. Of



No. 2.—Same case eight weeks after treatment with modified solidified carbon-dioxide; showing normal epithelial covering without scar formation.

10 cases of congenital naevi reported, 5 have been cured, 3 much improved, and the remaining 2 still under treatment, making a percentage of one-half cured. Two cases of lupus erythematosus were much improved.

C.—A report of 100 cases treated at the Flower Hospital Dispensary and the Metropolitan Hospital, of New York, shows fifty per cent. of complete cures practically including all types of neoplasms, which coincides with the reports of both

the Skin and Cancer Hospital and the Flower and Metropolitan Hospitals previously mentioned. Report B, however, shows only one-third cured in epitheliomas, one-half in naevi, and merely reports improvement in lupus erythematosus.

In my own report of 63 cases of cutaneous neoplasms successfully treated with carbon-dioxide, read before the West Jersey Homœopathic Medical Society at Woodbury, N. J., on August 18th, 1909, which included practically the entire category of cutaneous neoplasms, 62 cases were reported cured, and one case, which was a large cavernous angioma, was much improved with a white, scarless covering instead of its previous purplish hue, making practically a percentage cured of 98½. Of these, ten were epitheliomas of various types, all of which remain cured at this time of writing, having normal epithelial covering both in color and texture, and certainly with no apparent tendency towards return. The report further included the following:

Angioma Cavernos . . . . .	1	Morphea . . . . .	1
Chloasma . . . . .	3	Telangiect. . . . .	8
Deg. Seb. Cyst . . . . .	1	Lupus Ery. . . . .	2
Xanthoma . . . . .	2	Papilloma . . . . .	7
Shot Stains . . . . .	1	Keloid Cyst. Deg. . . . .	1
Naevi . . . . .	19	Tattoo Marks . . . . .	5
Chron. Leg Ulcer . . . . .		1	

Surely, this speaks well enough for solidified carbon-dioxide as the remedy par excellant in the successful treatment of cutaneous neoplasms. Two and a half years have elapsed since the time of my first report; hundreds of cases have naturally been treated since that time, not only in private practice but in the skin sections and dispensaries of the various institutions with which I am connected as well, and my associates all join me in a continuance of the admirable record of at least 98 per cent. of cures made, including all types of cutaneous neoplasms treated.

With reference to epitheliomas of all types, both superficial and deep, there can be no question of the superiority of carbon-dioxide,—the New York Skin and Cancer Hospital reporting but one-half cures with thoremadin, the Flower and Metropolitan but one-third, and another report from the same place, presumably a half. Carbon-dioxide does better than this—it practically cures them all, with perhaps but two per



cent. of failure. Lupus erythematosus treated by thoremadin by the New York Skin and Cancer Hospital reports 8 cases, 6 of which are still under treatment; one is cured and one is merely improved, showing 50 per cent. of cure. The records of the Metropolitan and Flower Hospitals show two cases of lupus erythematosus, reported by one authority as being much



No. 3.—Ulculo-hypertrophic type of epithelioma of long duration. Had resisted all types of topical treatment. Before treatment.

improved, and I would presume from the further cases reported from the Flower Hospital Dispensary and the Metropolitan Hospital that 50 per cent. were cured, as the exact report is not given.

Now, carbon-dioxide is absolutely certain in the treatment of all types of lupus erythematosus, and is practically the method of election in the treatment of this condition which has been so ably advocated by Gottheil, of New York. My own

success in the treatment of lupus erythematosus coincides with the results obtained by Gottheil and many others.

Now Bulkley says that he does not know whether the action of thoremadin is due to the sulphuric acid or the radio-active properties contained in the substance, or whether it is due to both. We do know that the use of acids is absolutely inter-



No. 4.—Same case nine weeks after treatment with modified solidified carbon-dioxide, showing smooth, scarless area with pinkish epithelial covering.

dicted in the successful treatment of cutaneous neoplasms because of their ever-ready tendency to want to break down and again degenerate, due to the inability of such substances to deeply penetrate and reach all of the affected cells.

I do not believe that we are satisfactorily able to explain the action of carbon-dioxide in the treatment of cutaneous neoplasms from the fact that by applying the intense cold to the affected parts there is set up an intense inflammatory reaction which, in turn, stimulates the tissues to reaction, thus enabling

them to get rid of the micro-organisms responsible for the existing conditions.

There is no doubt but that endartitis and thrombosis as well play an important part in the process of regeneration; thrombosis surely depriving a further blood supply to the frozen tissues.



No. 5.—Ulcerating Epithelioma of one year's duration. Had been treated with various topical applications without improvement.

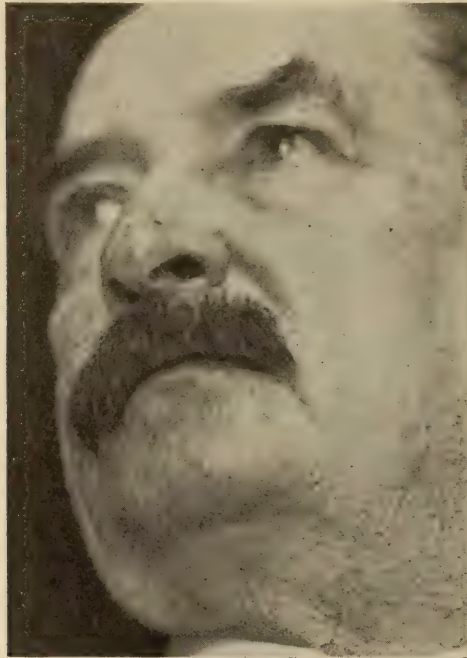
There is certainly a decided injury given to the neoplasms by the intense process of freezing and thawing. We can, as well, assume that there is produced autogenous immunization by the absorption of the products of inflammation, which naturally in turn have their beneficial influence upon the growth to be removed.

Surely, the action of carbon-dioxide can be regulated to better advantage than any other known substance. Naturally, its action depends upon the amount of pressure exerted and the time consumed, each cellular structure freezing the one beyond it, so that there is never at any time a question as to whether the entire base of the neoplasm can be reached or not, which



must be the case with such substances as pastes, acids and various other caustics.

It is a well known fact that such substances as silver nitrate and many of the acids produce albumenates, thus sealing the affected part over and merely irritating and acting as a stimulant, urging on the growths to renewed life and activity.



No. 6.—Same case, 12 weeks after treatment with modified solidified carbon-dioxide. Showing pinkish epithelial covering.

The duration of time is as well an important factor in treating cutaneous neoplasms with carbon-dioxide because of the fact that they respond much more readily and extend over a shorter period of time than with any other substance known in the successful treatment of these conditions.

Pain is practically a negative quantity, varying in intensity from that of nothing to sometimes decided pain, but, however, usually in those who have had previous X-ray treatment or who are of a neurotic temperament.

Surely, from the cosmetic standpoint there is nothing to be achieved which could be more successful in the production of normal epithelial regeneration than that to be obtained by the

use of carbon-dioxide. Furthermore, this substance can be used in and about the orbit without any apparent detriment whatsoever to the visual apparatus, which is not the case when various pastes and acids and other common escharotics are to be used.

The question of cost is certainly of paramount importance. When one has to consider the scarcity of radium and radio-active substances, naturally the cost must be considerable in comparison to carbon-dioxide which is so easily obtainable.

Therefore, I cannot quite see why radio-active and other chemical substances should be used, either in paste form or otherwise, when the results to be obtained from carbon-dioxide are so admirable from the standpoint of end results, and from the almost double percentage of cure to be obtained by its usage. I, as well, cannot quite see why various other chemical combinations, various acids, alkalies, caustics, arsenic paste, and the like, should ever be used in the treatment of cutaneous neoplasms because of their inability to deeply penetrate and because of their ever-ready tendency to form unsightly scars and their predisposition to want to again break down and degenerate with often greater activity than previously existed.

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#### A FEW DIAGNOSTIC SYMPTOMS OF SOME OF THE MORE COMMON DISEASES OF THE EYE.

BY

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(Read before the Philadelphia Academy of Medicine, February 1, 1912.)

SOME of the more frequent diseases of the eye with which the general practitioner is liable to come in contact are the various forms of conjunctivitis, keratitis, iritis and glaucoma, and it might not be amiss to consider some of the diagnostic features that present themselves.

The eye is of such vital importance in the conduct of the ordinary affairs of life, that we should always be on the alert to recognize particularly the more common diseases with which it is affected and then to treat as the condition demands. Delay in making the diagnosis may result in serious permanent

injury, which may add to some one's burden when considering the economic problems of life.

One of the excellent rules to follow in eye work is "be a routinist," that is to make it a regular habit to examine the eye in a routine way with each patient who complains of any eye condition and by so doing you will very likely escape missing some points that might be of considerable service. No matter what the patient complains of, let your examination cover the whole eye.

Begin with the eyelashes—see if any are distorted, see if the eye lids are abnormal or the lid edges are involved. Then consider the lacrimal apparatus. Don't be content with examining the bulbar conjunctiva, but if necessary evert the upper lids and thus see the under surface, where diseased conditions often hide their ravages. The cornea should next come under observation—see if it is transparent, of brilliant lustre, no break in the epithelium—then lastly we consider the iris—its color and lustre, its ability to contract and dilate and the size of the pupil as compared with the pupil of the other eye. Following such a rule a few times makes its application very quick and of great service.

One of the first things to do following such an examination is to test the patient's vision—particularly distant vision and to make note of the fact. It is always wise to do this before instituting any form of treatment, for sometimes following quite trivial involvement, the patient may discover the vision of one eye to be very poor, and it may have been so for a long time but may have escaped his attention until the present time. A record of the vision at the first visit if it is possible to get it, is necessary to a complete record.

The general appearance of the eyes of the patient will often go a great way toward helping make the diagnosis—a patient who shields the eyes from the least light and holds the head down, will lead you to suspect a lesion of one of the vital structures. If the eye lids are somewhat reddened, especially on the edges, some muco-purulent discharge and no particular photophobia, your diagnosis will probably be one of the forms of conjunctivitis. If such is the case you will find on closer inspection that the injection is particularly marked on the palpebral surface of the lid and considerably on the ball, but fading away as the vessels near the cornea. You can readily see that the injection is superficial from the fact that



the vessels can easily be moved on palpation. By following the routine examination as suggested above you can practically diagnose the case by exclusion. As regards the form of conjunctivitis we have to deal with, only a bacteriological examination will disclose.

If the patient complains of epiphora, it may be due to errors of refraction or to a contracted puncta or to a stricture of the nasal duct. Inspection will show whether the puncta is the part involved. I have had two cases recently—one with absence of the puncta on each lower lid but present in the upper lid and the other with an absent puncta of the lower lid of one eye that complained of epiphora of rather recent date and the examination disclosed the absence of the puncta as an anatomical curiosity, but the probable cause in each instance was some error of refraction, as the complaint was of too recent origin to be due to the absent puncta. If pressure over the lacrimal sac causes regurgitation of mucous, we know then that we have an obstruction to the outlet of the lacrimal sac, very likely a stricture in the nasal duct. The use of an eye wash or apparently indicated remedy will not relieve the condition and it is better for you to make the diagnosis than your competitor across the street.

When a patient complains of pain in the eye, it always means an involvement of one of the vital structures of the eye, such as the cornea, the iris or the ciliary body. The ciliary body is the highly vascular structure attached to the sclera about five millimeters behind the limbus and from which springs the iris and the suspensory ligament, which controls and supports the movements of the crystalline lens. It is of nutritional value to the lens and to the vitreous, and any involvement of it you can readily see is liable to cause serious impairment of its function.

Another symptom always present when the cornea, iris or ciliary body are involved is what is termed ciliary or peri-corneal injection—an area of deep injection immediately surrounding the cornea. The presence of this ciliary injection will at once tell you that one of the vital structures of the eye is involved and then you must endeavor to diagnose by exclusion or otherwise, which part is affected.

The presence of pain as above stated always means an involvement of one or more of these structures, but I desire to lay stress on the point that—absence of pain—does not necessarily exclude their involvement. It is such cases that occa-

sionally give rise to errors in diagnosis. I have on several occasions found that because of the absence of pain, physicians have been misled into thinking a serious condition only a trivial one. Always remember that whether pain is present or not, if you have any ciliary injection, you have a serious condition to deal with.

If the cornea is the structure affected we will have some break in the epithelial surface or a lack of lustre, or we might say that you will be able to see the cornea. Ordinarily the normal healthy cornea is so transparent that it is often difficult to clearly outline it. A slight elevation on its surface may appear as from the presence of a foreign body. Direct or oblique illumination or the use of the condensing lens will readily disclose the trouble.

If the iris is the structure involved we will have a change in its color from the loss of its normally bright lustre and distinct color to one of a dirty or muddy hue, especially noticeable when compared with the other eye. The condition of the pupil is a valuable aid as it will be decidedly smaller than the pupil of the other eye, the reaction to light will be sluggish or absent, and the use of a mydriatic will frequently disclose the presence of synechia.

The involvement of the ciliary body as a distinct entity is somewhat unusual, as it is usually associated with an iritis. One or two symptoms especially indicative of its affection are great pain, aggravated by pressure of the area directly posterior to the limbus. An eye affected with iritis alone will frequently permit a rather free palpation, but when cyclitis has developed exquisite pain on palpation is readily noticeable.

Deposits on the posterior surface of the cornea, at the lower part is another symptom generally indicative of ciliary involvement. The condition of the pupil may be unaltered.

Another condition in which we have great pain and ciliary injection is inflammatory glaucoma. It is of vital importance that you should be able to diagnose this condition immediately as delay in instituting treatment may mean the loss of an eye as far as useful vision is concerned.

Some of the symptoms are decidedly similar to the symptoms of iritis or a keratitis—we have the pain and the ciliary injection, but the pupil in glaucoma is always dilated in contradistinction to iritis, where it is contracted. The reaction to light will also be sluggish or abolished. Another distinguish-

ing symptom is—increase in tension—the eye will appear quite hard when palpated. Compared with the other eye the change will be distinctly noticeable. The cornea will be insensitive to touch, using a small pledget of cotton so as not to scratch the cornea. In iritis there will be no increase in tension and the cornea will be quite sensitive to the touch. The point that will first of all attract your attention to the possibilities of either an iritis or glaucoma, will be the condition of the pupil. To summarize a few of the distinguishing symptoms:

*Glaucoma.*

Pupil dilated.  
Cornea insensitive.  
Tension increased.  
Ciliary injection.  
Pain.

*Iritis.*

Pupil contracted.  
Cornea sensitive.  
Tension normal.  
Ciliary injection.  
Pain.

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**A FRAGMENTARY REPORT ON ONE HUNDRED LAPAROTOMIES.**

BY

NATHANIEL F. LANE, M. D., PHILADELPHIA.

(Read before the Woman's Homoeopathic Medical Club of Philadelphia, November, 1911.)

It affords me great pleasure to make this very brief report upon the work done in the Woman's Southern Homœopathic Hospital, and to give in detail the history, course and treatment of a few of the most interesting of the cases.

This series of consecutive cases (something over one hundred) contains almost every variety of gynaecological operation, both vaginal and abdominal, some upper abdominal work, such as gall bladder operations, some kidney operations and a few breast amputations.

The technique carried out in your hospital in the preparation and after-care of the patients, and the careful asepsis practiced in the operating room, has enabled this work to be done without any operative mortality. Only two of the patients operated upon died in the hospital and they were incurable cancer cases, both of them dying about three months after operation from exhaustion, due to the disease. Many were combined vaginal and abdominal operations



All this is very gratifying to report, as the attention which is given to the preparation of the patient, operating room and dressings and the care which the nurses exercise in the operating room at the time of the operation, is indispensable to the success of the surgeon. Successful surgical work cannot be done without the hearty co-operation of the hospital corps.

It is quite possible that the patient may pass successfully through the operation and yet through the carelessness of a nurse, assistant, or the operator, may suffer a slight infection which will interfere with the success of the operation as regards a cure of the symptoms for which she submitted to the operation. The patient naturally expects these symptoms to disappear and if this is not realized she considers the operation a failure and of course it is, no matter how skillfully the surgeon may have performed his work. In other words, it is the morbidity as well as the mortality that we should seriously consider.

When you get into your new hospital next Spring the work will be much easier, but notwithstanding this fact, the same care should be exercised, remembering that as "eternal vigilance is the price of liberty" so it is also the price of successful surgical work.

I have selected five cases from this number which I think will be of interest to you as they are a little out of the ordinary.

CASE I. Mrs. E. H. R.; age 44; occupation, nurse. Has had fourteen children and two miscarriages. All the births were instrumental. Menstrual history about normal except that she had pain at times. Leucorrhea profuse.

Family History: This is unimportant except that her mother died of cancer of the liver, and a brother died of spinal meningitis.

Personal History: When a baby she had a fall and did not walk until she was four years old and her back has always been weak. She had the usual diseases of childhood, also typhoid fever at 24 years of age and pneumonia at 25. She was operated upon five years ago by the writer for a lacerated perineum and cervix. About four years ago she was in a hospital in this city for three months suffering from an attack of peritonitis, the cause of which was not determined at the time of operation. The abdomen was opened from the symphysis to the umbilicus and was freely drained with gauze.

Present Illness: For the past six months she has had severe

pain at her menstrual periods which compels her to stay in bed for a week. This is accompanied by a profuse flow and vomiting. She has pain in the right hypochondrium with soreness and says that a lump seems to rise up in that location. Backache and headache are often present. She suffers from indigestion and flatulence, vomits at times, is badly constipated and is getting much worse lately. There is an immense incisional hernia, the result of the previous operation for peritonitis.

At the operation, which was performed August 19th, 1910, the hernia was found to be of the dissecting variety (the patient, by the way, weighs 250 pounds) with a ring four inches in diameter. The coils of intestines had burrowed out into the flanks, beneath the fat, in numerous pockets, and many of them were adherent to the sac. The abdomen was full of adhesions, every coil of intestine was adherent to another coil, the abdominal wall or some adjacent organ.

Where the intestines were injured by liberating the adhesions, they were repaired by Lembert sutures of linen. One knuckle was adherent to the sac in such a manner as to cause almost complete obstruction, thus accounting for the obstinate constipation. The sac was dissected out as much as possible, the uterus was fixed to the abdominal incision, the intestines were freed enough to approximate the edges of the ring without constricting them, and the hernia closed.

The upper abdomen could not be palpated through the lower incision on account of the dense adhesions and as the operation had already occupied a longer time than I wished to keep the patient under ether, the upper abdomen was not opened.

Although the history pointed to gall bladder disease, we hoped that the obstruction found would account for her pain and indigestion. While the hospital record does not so state, still I think a curettage was performed.

The patient recovered nicely from the operation, but unfortunately there was a slight formation of pus in the lower angle of the incision which, although it did not seem to be deep, probably did weaken the union of the edges of the hernia. She was discharged well in three weeks. The records show that she began to have natural bowel movements immediately following the operation and complained of the pain in the hypochondrium but once after she recovered from the anesthetic.

She soon resumed her work of nursing and was comfortable for some time, but would occasionally have attacks of pain

in the right hypochondrium and in a few months these became so severe that morphia was required for their relief. She also began to have pain at her menstrual periods. About two months before her second admission to the hospital, a small hernia developed at the site of the suppuration in the lower angle of the wound.

About one year after her discharge from the hospital she came to my office, at the suggestion of her physician, complaining of increasing pain at her menstrual periods and especially of the pain in the right hypochondrium, which again required morphia for its control. She was suffering from indigestion and flatulence to a marked degree. There was, as I said before, a small hernia at the lower angle of the incision. The liver was three fingers breadth below the costal border.

I recommended a cholecystomy, a repair of the hernia, a removal of the ovaries (she was entering the menopause and I wished to relieve the pain in the pelvis which troubled her only at her menstrual periods) and a fixation of the uterus.

She entered the hospital and was operated upon August 23 of this year.

The repair of the hernia, removal of the ovaries and the fixation, was much to our disappointment, a very tedious operation on account of the adhesions which had to be separated carefully to avoid injury to the intestines. She was under ether for about an hour for this part of the operation.

As the patient was in good condition the upper abdomen was opened and we found adhesions just as bad as they were in the lower abdomen. The gall bladder could not be seen until adhesions of the intestines to the liver and to each other were separated, when it was found low and back near the kidney. After some of the adhesions were released, the fundus could be delivered into the bottom of the wound and was found to contain one stone about the size of a chestnut and about two hundred smaller stones the size of a split pea and some fine gravel. There was neither mucous nor bile in the gall bladder and after removing all stones and gravel the bladder was drained, the wound being closed in the usual manner. This was, I think, my longest operation, the patient being under ether a little over two hours, the operation occupying nearly two hours.

You may say, "Why not remove the gall bladder?" and under ordinary circumstances that would be a just criticism;



but with the extensive adhesions and the loss of blood which its removal would have entailed, and the prolongation of an already dangerous length of time to keep a patient under an anesthetic, made it seem prudent to desist. As a matter of fact, the gall bladder was not functioning as there was neither bile nor mucous in it.

She recovered from the ordeal nicely, giving us some little anxiety the second night, but after that recovery was uneventful.

Since leaving the hospital she is apparently well, being entirely free from pain. The gall bladder was drained for three weeks (the time of her stay in the hospital) and healed promptly within a few days after removal of the drain.

CASE 2. This case is reported as representing a class of cases which, while appearing surgical, are probably not often benefited by operation and they require very careful discrimination.

Mrs. E. R.; age 36; seamstress; married; Roumanian.

Family history is negative except that her mother died of some bowel trouble. She was healthy as a child. Constipation began about twelve years ago, and is very obstinate, requiring large doses of purgative medicine to move the bowels thoroughly. About 10 years ago she began to have pain in the lower abdomen which has been gradually getting worse. She was operated upon by a celebrated Philadelphia physician for a tear of the perineum and in addition there were two incisions made, one in either groin, which evidently meant an Alexander suspension of the uterus. One year later the same surgeon made an incision over each kidney, probably a suspension of the kidneys. Soon after the kidney operation there was an incision made in the epigastrium and the stomach suspended, which completed the suspension of almost everything that could be suspended.

Present History: Her pain was not improved by all this operating and she still complains of pain in the umbilical region and the hypogastrium. The pains come on after eating, are of a crampy nature with burning and dizziness. She expectorates considerable white mucous at night. She retains her urine with difficulty for any length of time, is constipated and has no desire for stool and laxatives give her severe pain. She has lived on health bread for the last few years and says she is not

constipated while so doing. All her statements must be taken "cum salis."

Treatment: She had liquid diet for a few days with very little pain and was then put upon house diet for a week with apparent comfort. She then began to have pain and we were forced to procure the "health bread" for her, but this did not help matters materially. In fact, she was so changeable and hard to manage, that we were very doubtful of the advisability of operating upon her. She finally refused to try further treatment and requested an operation, otherwise she would leave the hospital. As we wished to give her every chance, and as, from her story, her pain had always been in the lower abdomen, and furthermore as the lower abdomen had never been opened, we finally consented to make an exploration of this region.

Operation: The omentum was found adherent to the abdominal parietes, the bladder and uterus. There were numerous adhesions around the round ligaments and tubes (probably the result of the Alexander operation); there were numerous small cysts in the vicinity of the tubes and round ligaments on both sides, the left ovary was cystic and the right ovary small. The left tube and ovary and the appendix were removed, the adhesions broken up, the numerous cysts evacuated, and the entire intestinal tract explored for obstruction; but none was found. On account of the adhesions in the region of the stomach, where it had been suspended, the upper abdomen could not be satisfactorily palpated.

Recovery from the operation was uneventful; her highest pulse was 100 and her highest temperature was 100. She had the same diet as the other patients having a similar operation. She complained of severe pain on the seventh day, but she was fairly comfortable during the balance of her stay in the hospital, although she was very vacillating. She was discharged in good condition.

She came to my office some weeks after her discharge from the hospital and was delighted at her recovery; she said she was perfectly well and could hardly realize the fact. Here the story should end, but a few months later I received a letter saying that she was suffering just as much as before the operation. The last I heard from her she was under medical attention and was feeling somewhat better.

This patient had had all sorts of treatment, both regular and

homœopathic, as well as the rest cure, before she came to the hospital.

I know that many physicians will say that she was a neurasthenic and that her sufferings were not real, and it may be so; but personally, I feel that there is something the matter with these patients that we do not discover and that we should not be too quick to consider their sufferings imaginary.

CASE 3. Mrs. May C.; age 33; no children or miscarriages.

I saw her the first time about a year before operation. She was very nervous, intercourse was very painful, she suffered from dysmenorrhea, and had more or less pain constantly in the right iliac region.

Examination: A large mass was found to the right of and posterior to the uterus, apparently attached to it, and not very movable. Diagnosis was a fibroid.

Operation: A fibroid of moderate size was found as well as several smaller ones. The tubes were covered with tubercles, otherwise they were normal. A supra-vaginal amputation of the uterus was performed with the removal of the right ovary and both tubes. The left ovary was left as we did not care to precipitate the menopause on account of her nervous temperament. The tubercular condition was entirely removed as it was confined to the tubes.

Her recovery was remarkably smooth; she did not have a symptom after recovery from the ether.

In addition to the tubercular condition, another point of interest is the fact that she menstruates regularly from the cervical stump.

CASE 4. Mrs. Lillie L.; age 21; obstetric history not recorded.

She had a miscarriage about two weeks before admission to the hospital, at the eighth month of pregnancy. The history following the miscarriage is very vague until about the eighth day, when she was taken with a violent pain in the abdomen, of a crampy nature and a profuse vaginal discharge.

When admitted to the hospital she was in a profound state of shock from sepsis. She was short of breath, was in a cold perspiration, complained of a sensation of a weight on her chest, was vomiting, bowels were loose, she was unable to sleep, was anxious and did not want to be left alone. The temperature was 96, pulse 120 and of very poor quality, respirations 44. Examination showed a greatly distended abdomen,



very painful to the touch and a fluctuating mass in the cul-de-sac.

She was very lightly etherized and the abscess quickly opened and drained through the vagina. Smaller abscesses were opened with the finger and drained into the larger cavity, the entire operation not occupying more than two or three minutes.

For the next week she improved, but not as rapidly as we wished. Her pulse went as high as 148, the respiration running between 36 and 48. The temperature was mostly low, fluctuating between 97 and 102 except immediately after the operation when it reached 104. Another abscess cavity was evacuated three days later by the douche nozzle, it evidently being just about to evacuate itself spontaneously. In each case the pus was copious in quantity and horribly offensive.

Two weeks later another abscess was discovered about the point above Poupart's ligament. The patient was etherized and I was able to evacuate it through the old incision in the vagina without opening the abdomen. Following this she made a slow, but satisfactory recovery. She was admitted to the hospital on November 29th, and discharged February 3d.

Examination upon her discharge showed the pelvic organs in a remarkably good condition considering the seriousness of the infection.

CASE 5. Mrs. Mary F.; age 61; has had seven children, the last thirty years ago. She says she had convulsions with each birth. Was operated upon fourteen years ago for a tumor of the uterus at which time the right ovary was removed. Three years ago she had an appendectomy performed, peritonitis following the operation. Eighteen months ago she had an abdominal operation performed, the nature of which is unknown, and six months ago she had an operation upon the bladder, the nature of which is also unknown. She reports having had "abscesses on the bladder" with discharge of pus through the urethra, for years, at intervals of about two months, but we observed no such phenomenon during her stay in the hospital of nearly three months. Her right leg was paralyzed last year, is better now, but she cannot walk. Every few months she has a hemorrhage from the uterus which is dark and clotted. She has a constant, dull pain in the bladder region which becomes severe before, during and after urinating. She requires catheterization at times. Is sleepless.

A cystoscopic examination by Dr. Ashcraft showed a general cystitis and trigonitis. For some time before I saw her she was treated for the cystitis by bladder irrigations and medicines.

The following notes occur on the chart November 16th, one month after admission to the hospital: "Dull constant pain in the lower part of the abdomen which sometimes becomes sharp and crampy. Must lie still, cannot walk or sit on account of the pain in her side. Back is painful the entire length of the spine. Cannot lie down without assistance on account of stiffness in the back. Frequent desire to urinate with smarting and burning about the urethra, worse at night. Is constipated, cannot remember when she had a natural bowel movement, and has no desire for stool. Headache and dizziness."

I examined her first on the third of December. I could find nothing wrong in her pelvis or abdomen for a woman of her age and recommended waiting and continuing medical treatment for a while.

As she was not much better two weeks after the first examination, I consented to make an exploratory incision and examine the contents of the pelvis and abdomen for the cause of her suffering.

As the left iliac fossa was the seat of most of her pain, we carefully explored this region and were rewarded by finding an adhesion reaching from the sigmoid colon, high up, to the seat of an operation on the left broad ligament. This band was the size of large wrapping twine and very firm. This was released and after a thorough search of the abdomen, which included the ureter and kidney, the abdomen was closed.

Her pain ceased on the fifth day after operation and she gradually improved and expressed herself as being very comfortable. The only set back she had was a swelling of one ankle after she began to walk, but that soon became better and she walked out of the hospital one month after the operation, saying she was well.

Some months after leaving the hospital she reported that improvement still continued; instead of being practically bedfast for most of four years she was doing some housework.

There were many other interesting cases in this series, but I will not tire you with a recital of more at this time.

## Transactions of the Homoeopathic Medical Society of the State of Pennsylvania

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### BUREAU OF CLINICAL MEDICINE

M. M. FLEAGLE, M. D., Chairman.

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#### ANEURISM OF THE AORTA. REPORT OF A CASE.

BY

HORACE G. CARMALT, M. D., PITTSBURGH, PA.

CASE HISTORY.—Male, aged 32, switch repairman for last 5 years. On February 21, 1911, complained of shortness of breath, cough and at times slight chest pain. Family history shows arteriosclerosis. Father, a painter, died of apoplexy; mother epileptic; maternal aunt asthma and dropsy. Personal history. Always good health; exposed to gonorrhea at 20, denied syphilis (Wassermann test later was negative), had urethral operation three years ago; used both tobacco and alcohol injudiciously, followed the painter's trade at 17 and for 10 years after; had been under a doctor's care for four months when present illness began with hoarseness, cough worse at night and later blood spitting; temperature 99 to 99.5 degrees, and had lost six pounds. Examination showed a man well built and muscularly compact, pulse 112, temperature 98.8 degrees, respiration 22, blood pressure 130, throat inspection negative; chest, harsh breathing infra-clavicular region, with percussion note high pitched; also a little pleurisy friction. Heart negative except for rapidity.

Two days later was called to patient's home; patient dyspnoic, had a right-sided broncho-pneumonia, cough and breathing worse lying down, bloody sputum, but negative as to the pneumococci present; urine 1018, albumen, a few narrow and broad hyaline casts. Chest gradually cleared up, but rales in right chest and apex persisted for three months. A positive diagnosis could not be made, but patient was treated as a suspected tubercular. With rest in bed, fresh air and three glasses of milk and egg daily there was gradual improvement until the



middle of May. Cough and blood spitting ceased, temperature normal and pulse dropped to 84. At this time patient felt he must get about. With exertion came aggravation. Rest was advised, but patient surreptitiously took trips that explained afterwards some of the aggravations. During the month of May, when the general improvement changed for the worse, search was made for the cause. Sputum was again negative, hemaglobin 95 per cent., urine contained a trace of albumen, but nothing could be found in lungs, heart or aorta to explain symptoms. At this time patient exhibited a wonderful caput meduso, and petechial veins in the left costal arch. Veins of left arm were most distended. Following an attempt to rake up his yard he had a severe occipital headache with dilation of right pupil. Belladonna and rest relieved in two days. The left pulse was less strong than the right.

June 20th, Dr. F. D. Stolzenbach was called in consultation. Patient was carefully examined. Pulse 96, temp. 99 degrees, blood pressure 145, cardiac area small, apex displaced toward median line and downward; lungs hyper-resonant, moist rales in right apex, rough breathing right anterior chest, arteries slightly sclerotic, right thyroid a little enlarged; chest and neck veins distended and prominent. Diagnosis, asthma, *R* K I and bromides. For 24 hours patient was free from attacks, then violent spasmodic asthmatic seizures began again. A second consultation was had. Dr. Emmerling, Sr., examined chest, looking especially for aneurism, but findings were negative. Diagnosis, pressure asthma. *R* K I and Hg. Patient grew worse. On the 27th a laryngoscopic examination by Dr. Chevalier Jackson showed complete paralysis of left vocal cord, explaining hoarseness and brassy cough. Then an X-ray was taken by Dr. Geo. C. Johnston. The plate showed a tumor in mediastinum, directly above heart and of much the same size and shape. Patient was then sent to South Side Hospital ward for a week. He grew worse; hospital atmosphere was adverse. A consulting surgeon, Dr. R. J. Miller, was called and patient was moved to St. Francis Hospital for an exploratory operation. Upon removal patient began to feel better,—hospital environment was congenial,—and attacks of dyspnoea grew lighter and less frequent. Meanwhile a number of physicians saw and studied the case. A diagnosis of sarcoma was favored and Coley's serum, 1-4 to 7 1-2 m. was used for three weeks. Patient continued to feel better, but area of dullness, which was

not made out until after X-ray, gradually grew larger. During the last week pulsations could be seen in 2d interspace, but no thrill, nor bruit, nor bulging was detected, and the only complaint was a feeling of slight compression or a little intercostal pain. There was still hoarseness and brassy cough, and slight dyspnoëic attacks, but the distended veins grew smaller and pa-

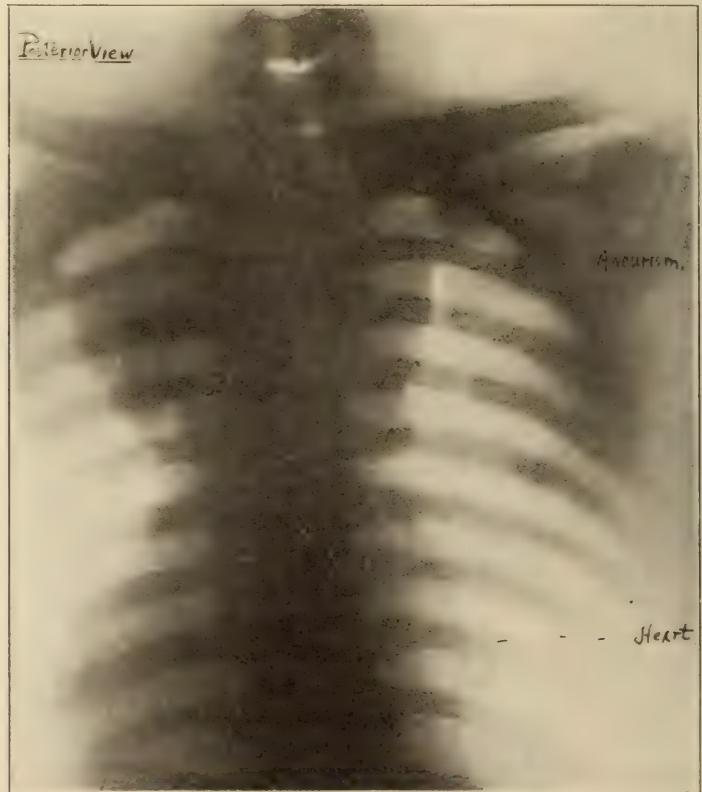


Fig. 1. Radiograph Showing Aneurism. Posterior View.

tient felt better. Sunday, August 6th, after some slightly disturbing news, patient had a mild asthmatic or dyspnoëic seizure. The next afternoon, suddenly, he was taken with a violent attack, became cyanosed, and was gasping for breath. Nitroglycerin 1-100 was used, then 1-6 morphia hyp., then venesection to 300 c.c., finally tracheotomy and a catheter was passed down trachea with moderate relief, but patient grew weaker and died at 11.30 P. M.

The post-mortem showed a mass the size of a large orange, which proved to be an aneurism of the arch of the aorta. (See cut.) Over the front of the tumor and pressed up against the sternum were the distended returning veins. Posteriorly the trachea was displaced to the right, but not completely occluded. The wall of the aneurism was thin and friable. Part was un-

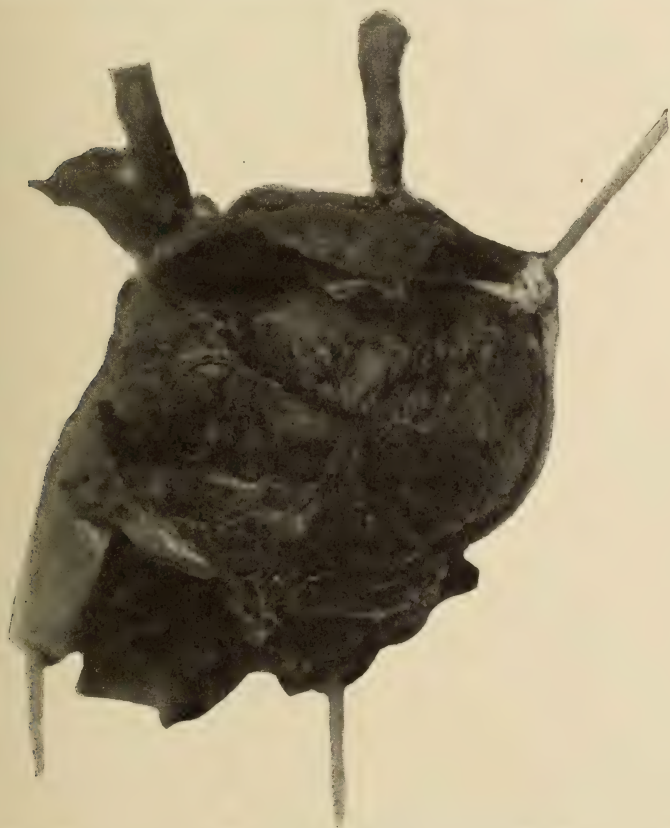


Fig. 2. Aneurism of the Arch of Aorta. Splint stuck in organized clot. String passes up aorta, over organized clot, and out the descending aorta.

avoidably torn away during removal. It seems probable that any increase in blood pressure would distend the aneurismal sac and compress the overlying veins in front and the trachea behind. This may be the explanation of the relation of attacks of dyspnœa and cyanosis to nervousness, excitement and exertion. The adjacent arteries were slightly sclerosed. An organized thrombus was found inside almost completely filling the aneurismal sac.



After the autopsy it was astonishing that the diagnosis could have been missed. But upon reference to the literature, both Strümpel, the German clinician, and Hirschfelder, of Johns Hopkins, point out that some cases almost defy diagnosis. The latter says: "The symptoms, signs and diagnosis present no specific features except the ease with which other aneurisms may be overlooked after one is diagnosed. Personally, the failure of so great a number of observers, some twenty, to diagnose this case has given the writer greater respect and greater reverence for the power of diagnosis held by physicians. In this case the fluoroscope should have been used. Both hospitals have X-ray rooms, but no one urged the use of the fluoroscope, and on June 27th, the writer did not have the familiarity with aneurism that he has at the present time. But a lesson has been learned, and that is to have the fluoroscope used in all mediastinal growths. However, the writer has the melancholy satisfaction of having told the first consultant, after the revelation of the X-ray, that the factors in the case—lead, alcohol and tobacco, together with a comparatively recent change to work that required severe exertion, paralysis of vocal cord, ocular disturbance, small left radial pulse, engorged veins of chest and left arm, all pointed to aneurism. But because there was neither bruit, pulsations nor tracheal tug this tentative diagnosis was discarded in favor of sarcoma.

The following resume is taken largely from Hirschfelder's excellent chapter on aneurism. Galen seems to have been the first physician to recognize aneurism, about 200 A. D. Pare suggested venereal diseases as the cause, but Lancisi, in 1728, definitely demonstrated syphilis to be the important factor. In 1805 Scarfa made the next important contribution when he demonstrated the weakening of the middle arterial coat, which is the basis of the modern pathology of aneurism. In 1875, Koester showed this weakening was due to inflammatory changes of the vasa vasorum. As a consequence the muscle fibers degenerate, then pressure forms aneurism. But alone blood pressure will not cause aneurism.

An artery ruptures at 1,680 to 4,000 m.m. Hg. Ordinary pressure ranges from 105 to 160. Simple arteriosclerosis which essentially is a thickening of the intima does not weaken the arterial wall and plays no role unless the media be injured. Erb's experiments show that adrenalin will produce a mesarteritis without change in the intima. Other

toxic substances as lead, alcohol, nicotin, bacterial toxin, lactic and other acids also produce mesarteritis.

Syphilis is estimated to produce 50 to 90 per cent. of aneurisms; then alcohol, lead, hard work and tobacco. Aneurism causes .6 per cent. of all deaths. The ascending aorta is the most frequent location, but those in the abdominal cavity are more accessible to surgery. The prognosis heretofore has usually been a question of months, but Hirsh and Robbins report a case of pulsating tumor of twenty-five years standing, during which time patient did hard work. Rupture is the frequent ending. When there is a cure it is essentially by organizing a clot, produced by slowing the current of blood with some injury to the intima plus fibrin ferment. Symptoms:

1. Visible mass, pulsation or thrills.
2. Cough—common.
3. Vocal cord paralysis, brassy or paretic cough.
4. Paroxysmal dyspnoea, or so-called "asthma."
5. Pain—anginal, down arm due to pressure on aortic plexus; localized or referred pains, intercostal.

Physical signs and aids:

1. Visible mass, pulsation or thrills
2. Auscultation usually shows systolic murmur over aneurism.
3. Percussion—dullness; great care to detect.
4. Heart may be displaced.
5. Unequal pupils—pressure on sympathetics.
6. Tracheal tug, shown in 40 per cent.
7. Tracheal percussion shock—feels like tapping a hot water bottle; shown in 60 per cent.
8. Inequality of pulse.
9. X-ray picture.
10. Fluoroscope—best of all.

*Treatment.*—In 1700 Valsalva recommended rest, starvation diet and frequent bleeding. The two former are still recommended, using 10 oz. liquids and 10 oz. solids daily, for several weeks. Calcium lactate, modified diet and rest and subcutaneous 10 per cent. gelatin injections are recommended. K I is most used; perhaps it causes a retrogression of the mesarteritis or as Gibson suggests, the nutrition of the walls of the entire arterial system undergoes improvement. Wiring is used especially in the sacculated form. Halstead's aluminum bands give promise. But best is arteriorrhaphy, suggested by

Mates, 1905. In 86 cases by 52 operators there were 78 recoveries. It is done on the principle of the hernia operation—"obliterate the sac." This method offers most hope, and it makes it relatively of greater importance to recognize early abdominal aneurism (here pain is a chief symptom) because the abdominal aorta is accessible to surgery.

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### GASTRIC NEUROSIS.

BY

R. L. PERKINS, M. D., HARRISBURG.

THE differential diagnosis between functional disturbances of the stomach due to impairment of the nervous system and those caused by a lesion of that organ have often tried our skill to the utmost.

How often in our zeal while searching for lesions or growths and in examination of stomach contents we overlook the important factor of the make-up of the patient and the condition of the nervous system.

Neurasthenic patients often mislead us, as the least symptom is exaggerated until it assumes large proportions; they insist that there is a growth or an enlargement of the stomach and according to their statements it can at times be palpated.

If the physician tries to assure them that the disturbance is due to the nervous system and not a lesion of the stomach his statement is doubted, especially if it be a man, as to call him nervous hurts his pride and seems to place him as a weakling among his fellows.

A lesion of the stomach in a neurasthenic is a condition which must not be overlooked, as functional disturbances of the stomach will cause malnutrition, which is bound to disturb the nervous system and cause reflex symptoms which will be most prominent in the weakened organ and thus bring about a complication.

A physical examination is always necessary, as a lesion in an adjacent organ may cause the most distressing gastric symptoms, and treatment properly directed will cure an apparent gastric neurosis. These cases have inherited a nervous constitution or worry, mental exertion or dissipation have



brought on a case of nervous prostration and some slight disturbance of the stomach may bring on a train of symptoms which have no end, especially if the patient gains access to medical literature. The consideration of a few conditions commonly found may be brought up for discussion with interest at this time.

Gastralgia may appear before the nervous symptoms are in evidence, but usually follows mental overexertion or emotional shocks. The pain comes without warning, is of a burning, boring character and is independent of meals, the character of food having no bearing on the case. However severe the pain, strong pressure generally relieves, while lighter pressure is not well tolerated. It disappears suddenly and may be followed by a desire for food which does not in the least disturb.

If the history is carefully taken it will show a run down condition of the nervous system, mental over-exertion and a train of symptoms, such as headaches, insomnia, an irritable, nervous condition and lack of interest in daily duties.

In ulcer of the stomach the pain comes immediately after eating and is relieved when the stomach is empty. If there is no hemorrhage, blood may usually be found in the stomach contents or stools and a painful spot is usually to be located over the epigastrium.

In hyperchlorhydria the pain disappears after the ingestion of alkalies or albuminous foods and examination of the stomach shows HCl in excess.

In chronic gastritis the intense paroxysmal character of the pain is absent; it is more constant with marked distress after eating and the stomach washings show more or less mucus.

Nervous vomiting is independent of the character and quantity of food, generally occurring after more or less irritation of the nervous system. No premonitory symptoms may be present, the attack coming on after the ingestion of the simplest food or even on an empty stomach. We have seen patients who could digest the richest food with the mind at ease while the simplest food while under mental tension would cause the most distressing vomiting. The following recent case will illustrate some of these symptoms:

A female, aged forty-five, of a highly nervous temperament was operated for the removal of a large ovarian cyst and had a good start on the road to recovery. A few days after the operation over-zealous friends excited the patient, a chill fol-

lowed by a temperature of 104 degrees and severe vomiting came on immediately after her excitement. No cause could be ascertained and the temperature promptly subsided, but no food could be tolerated, even water causing burning and gas. The second day the same symptoms were repeated. The vomited matter containing nothing that could cause these symptoms we directed our treatment to the nervous system. Passiflora with strontium bromide promptly relieved. The patient now has a fine appetite; not even the richest food causes a symptom.

Nervous dyspepsia is a nervous disorder of the stomach, characterized by numerous distressing symptoms during digestion. On examination of the stomach contents we find them variable; at times normal and again the acid may be increased or diminished. This disorder occurs usually among the class who live under great mental tension, have been high livers, have disobeyed the laws of nature, disregarded rest and are now paying the penalty. After eating, a sensation of fullness occurs with belching and dizziness, a strong characteristic being that the quality and quantity of food makes little difference in the symptoms. The discomfort and pain may be present when the stomach is empty. The nervous system is in an impoverished condition, insomnia, headache, backache and lack of concentration are present. The patient is worried about his condition, loses confidence in his friends and cannot be consoled.

This trouble should be differentiated from other conditions by the mental symptoms, the character and quantity of the food having no bearing on the severity of the symptoms. A change of scenery away from the environment that caused the mental worry affords much relief, as peace of mind is the ideal state to properly control this disease.

A case under recent observation will illustrate this point. A promoter, aged thirty-five, previous health fair, of late having been under great mental pressure, developed a neurasthenic condition. He could not sleep well, little tasks seemed too great for him to accomplish, unable to concentrate thought; everything irritated him, even could not bear to have the children about. At this time his stomach began to cause much trouble. He had great distress after meals with eructations and weakness, the appetite was changeable, but the distress was the same whether the stomach was full or empty, dieting being of no avail. He could not be induced to leave his busi-

ness a day for fear that it would not be properly attended to and the fear that his stomach condition was malignant made him unfit to attend to business details. As he was an enthusiastic fisherman we finally prevailed upon him to go into the mountains with a party on a week's trip with no restrictions as to diet or living, being provided with a simple nerve tonic. The neurasthenic returned a well man. From his report he began to improve on the second day. He fished each day, came home tired and wet and was glad to eat what was placed before him. At the end of five days as he expressed it, "I was not aware that I had a stomach." His weight was increased twelve pounds, and to-day he believes fully that all work and no play is bound to bring disaster.

Atony of the stomach very frequently occurs in nervous diseases of the stomach associated with neurasthenia. Atony in a neurasthenic individual may produce nervous dyspepsia. What, in such a case, is primary and secondary can only be answered on the most careful consideration of the case in question. We do not wish to convey the impression that in a nervous condition of the stomach there are no structural changes, as such are bound to occur if the neurotic condition is not corrected. A constant disturbance of the functions of the stomach is bound to cause a lesion and the longer the condition persists the greater will be the change in the organ itself.

When we consider the situation carefully how can we expect this important organ to perform its proper duty when the system that governs the secretory, sensory and motor functions is impaired. The patient lacks nourishment, the nervous system sharing in this, causing more worry and the more the attention is drawn to the stomach the worse it becomes. We all know how we have struggled to correct nervous disorders and how hard it is to obtain the co-operation of the patient. In the majority of cases they are prone to take advice from friends and quacks rather than the honest physician.

In our treatment of these cases we must not overlook the building up of the patient, try to find him a hobby and any other means that will take his mind away from his condition. Relaxation is what he needs and we must in some manner relieve the tension of the nervous system. Remedies are very necessary, but our control of the patient is the necessary factor in the case, for without that we can accomplish little and I am sure with this and the proper study we can soon relieve the majority of our cases.



**REPORT OF A CASE OF ACQUIRED SYPHILIS TREATED BY INTRAVENOUS INJECTION OF SALVARSAN.**

BY

G. W. HARTMAN, M. D., HARRISBURG.

It has been said that syphilis, tuberculosis, and alcoholism are the scourges of the human race. Of these syphilis is far and away the ugliest and worst. Because of its prevalence and fearful effects it should be elaborated upon in medical societies so that thereby new measures for its prevention and control may be determined upon. Its horrors, its mode of transmission and symptoms should be spoken of, published in the press, and taught to the youth of the land. Every day sees new victims, and daily the sum total of their number increases.

Last year it was estimated that thirty thousand prostitutes lived and flourished in New York City alone. The money paid to them amounted to \$60,000,000. The inestimable harm these and the other thousands of their kind are doing all over this country by scattering syphilis and gonorrhoea broadcast makes one shudder. It will cost the nation many times sixty millions of dollars to purge itself of these maladies, and it will require quantities of salvarsan to redeem the syphilitic victims of these white slaves.

Syphilis is what Sherman called war, and, like war, it leaves in its wake poverty, broken hearts, distorted lives, and death itself. It is the most loathesome of diseases and one of the most destructive. No cell or tissue structure of the body is free from its destroying power. Its destructiveness would be all the worse to bear if it were known, as often happens, that the one most thought of and most loved is the one who transmitted the disease. It comes upon the victim like a murderer; sneaky, serpentine, subtle. It invades the sanctuary of the home and fireside, transforming domestic tranquility into domestic unhappiness, destroying man's best earthly possession—the home. In some families the culpability of the unfaithful one is not discovered, and the innocent wife accepts the scourge as a visitation of Providence.

The ignorance concerning the facts about the venereal diseases on the part of young women at time of marriage makes their infection the more rapid and certain. Forewarned is



Fig. 1. Condition before the administration of salvarsan.

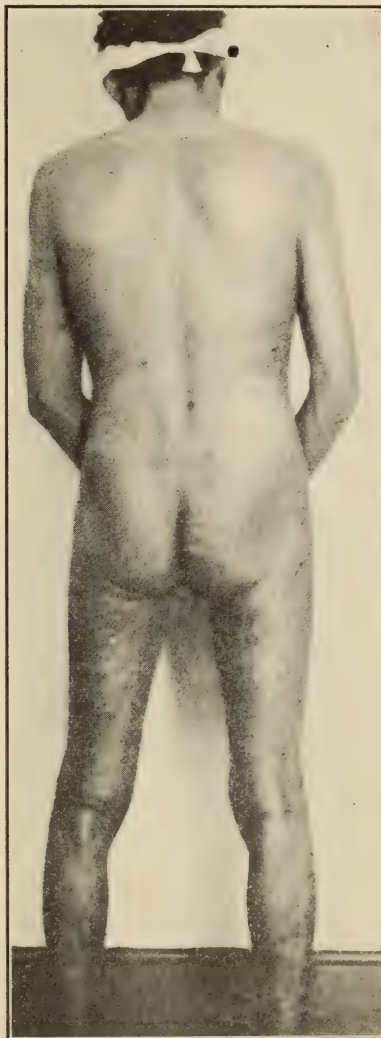


Fig. 2. Condition two weeks after salvarsan was administered.

forearmed. To forewarn is to give the near-victim of the disease knowledge of whom to avoid in order to be saved. Those who need especially to be warned are the occasional frequenter of the house of ill fame, and the chaste bride-to-be. The prostitute and the libertine are its chief purveyors and dispensers. The State owes to any woman who yields herself up to wifehood and motherhood a guarantee of future health because of the service: namely, replenishing the population, that she performs for the State

This is possible if prenuptial examinations are made and marriage forbidden those who cannot show themselves to be free of venereal disease. This can be done if we separate matters of public health from matters of public politics. When the compulsory examination of those who wish to marry is practiced, the cowardly rascal who has no regard for the health and safety of others will not apply. And when publicity is given to the fact that certain individuals have venereal disease such individuals will be avoided by their friends and the public. Precaution is better than cure. These are matters for legislative enactment.

Publicity must precede the lawmaking, because no law on this subject will be made effective that the people do not understand and endorse. Let the lay individual understand about the large number of fatalities, the suffering, and remorse associated with its possession and they will uproot instead of condone the evil. No one would fail to profit by the information that would prevent misery and pain and would overcome the loss of love and of money. Let our young people know the possibilities of venery. It would be much better for them to have such knowledge than to inform them of the details of murder cases and other scandals that daily confront them in the newspapers. No one seems to care about prophylaxis; but it will seem different if one's own friends become infected.

Prudishness prevents parents from passing along to their children proper information about their bodies that they should know. Adolescent children should be taught sexual hygiene, and facts about conception and gestation. Dangers of illicit coitus should be pointed out; also likelihood of contamination and life long suffering in case promiscuous cohabitation is indulged in.

Shaw says that every human being has a right to sexual experience, meaning free love. Such wild statements must be



opposed by the physician. There is no truth or sense in the doctrine of sexual necessity. Free love and convenient laying aside of the marriage vow is nothing less than prostitution and libertinism.

It is well known that all chancres are not "merited." Instance the infection by the kiss,—the kiss of passion or even the kiss of friendly greeting. There are many other grades and varieties of extragenital infection, not due to sexual contact.

Publicity seems to be the best prophylactic measure whether merited or unmerited cases are being discussed. Only the most degraded individual or one already diseased would willingly cohabit with a syphilitic. In the second place if syphilitics were known to the public the spread of the disease would automatically stop. That is, the class of cases called "unmerited" will be prevented.

The following history sets forth the progress of the case under consideration:

At age seventeen the young fellow became infected while "sowing wild oats." In a few weeks his chancre appeared. He consulted a physician and took treatment till he was pronounced cured. He appeared to remain cured for about ten years. His rash and other secondary symptoms were pronounced. He returned to treatment. He claims to have had continuous anti-syphilitic treatment ever since (thirteen years).

He married ten years ago; has a child five years old. Child seemed delicate but has had no disease except eczema on the face. Wife has had no miscarriages, and is not known to have been infected.

A short while before the case came to us for treatment the patient consulted a quack in a town of another State. His symptoms grew worse rapidly. Eruption was so extensive that it covered the whole body.

On July 21, on his first visit, the patient presented large ulcers of the mucous membrane of the mouth and on the tongue; also, lesions on the extensor surfaces typical of psoriasis and lesions simulating psoriasis about three-quarters of an inch in diameter, scattered over the trunk and forearms and legs. These were brightly inflamed but covered with scales. Besides these lesions there was a papular eruption on the flexor and extensor surfaces of the wrist and ankles, also on the face and feet.

On the feet the lesions were beginning to become vesicular and pustular. Patient gave a history of having had the psoriasis-like lesions at different times for the last four or five years, areas the size of a quarter on which were bran-like scales.

On July 23rd the papular eruption had become confluent over the areas named above and had become so extended that his hands, feet, face, neck, arms and legs were practically covered. Many of the papules had become pustules and some had ruptured. There were many vesicles and there was moisture on the surface.

On July 25th his mouth was very sore; he had no appetite and there was diarrhoea. The skin was cracked back of the ears and on the hands and feet. There was a great deal of oozing. The papular and pustular lesions were spreading rapidly over the whole body.

On July 27th his ears, face, hands, and feet were very much swollen. Much swelling about the eyes. Patient was suffering intensely. He could not get any rest at night. There was a great deal of crusting all over the body; the crusts resembling those of impetigo. The skin between the lesions was swollen and inflamed. Many scales were removed after softening them with olive oil and ointments. The ammoniated mercury ointment cleared up the crusting to a marked degree. This would seem to suggest that there was a secondary skin infection. On account of the difficult diagnosis of the surface manifestations we sent a blood specimen to the pathologist. This specimen was drawn by Dr. Abbott, my associate, on July 31st. In a few days we received an affirmative report on the Wassermann reaction. Having gotten this we were justified in administering the "606." The man's condition remained about the same in spite of the fact that he was receiving the mercurial treatment.

On August 4th the salvarsan was administered by intravenous injection. It was followed by a period of reaction lasting four days. There was an elevation of the temperature to 103 degrees. The urine analysis showed albumen and casts. The patient complained of burning, and large quantities of urine were voided. There was a profuse diarrhoea which lasted for fourteen days.

On August 10 the patient reported the first comfortable night he had had since treatment began. Slight improvement was noted in the skin lesions. The disease seemed to be ar-

rested. The urine was found to be free of albumen and casts. The crusts and scales were rapidly desquamating, leaving the skin markedly erythematous. The soles of the feet became loose and a little later came entirely off like a cast of heavy skin.

On August 28th the skin was practically free from lesions except on the extensor surfaces which were still covered with marks like psoriasis, and these were clearing up nicely. The face, hands, and feet were the last parts of the body to clear up. These spots were, no doubt, a syphilitic psoriasis because they were improved by the treatment. If they had persisted in spite of treatment we would conclude they were manifestations of a true psoriasis. There was still some erythema of the skin on this date, also itching and cracking.

Notwithstanding the fact that we have the history of a much earlier infection I believe we were dealing with secondary lesion, and that the fulminating type of the rash was due to improper treatment or no treatment at all.

The treatment of syphilis has been completely revolutionized by the discovery and use of salvarsan. As we have shown the superficial symptoms are promptly removed by it. The patients all say they feel better after a few days than they felt for weeks or months. To all appearances they are cured. Are they cured to stay cured? Are the effects of the disease removed along with the destruction of the spirochaetae? Fournier says that it is one thing to treat *symptoms* of syphilis but quite a different thing to *cure* syphilis. We do not know even now whether a man once infected is ever in after life a disease-free man, one who can become the same physically that he was before. If he can not, he does not represent a perfect cure.

In summing up we find, first, that syphilis is much more prevalent and disastrous in its effects than is commonly supposed.

2. It is transmitted because of ignorance of both cause and effect.

3. Publicity concerning venery is essential to public health.

4. Pre-nuptial examination of the sexes is desirable.

5. This patient was untruthful or these secondary lesions came unusually late. They were extremely severe.

6. Salutary and prompt results following the use of "606."



## BUREAU OF SURGERY

G. B. MORELAND, M. D., Chairman

### ACCIDENTS AND EMERGENCIES.

BY

R. E. TOMLIN, M. D., PHILADELPHIA.

MUCH depends upon the definition, or meaning of a term.

It is the writer's wish that the terms used should be considered in their broadest signification. The following paragraph was taken from a current periodical—(August 30, 1911): "The 'Zoo's' Hospital is in charge of Dr. ———, who must be prepared at any moment to treat a wide variety of complaints, from the broken leg of a dainty gazelle, to the toothache of a tiger. Every kind of bird, beast, and reptile has the advantage of the best medical and surgical treatment, and nursing in the event of illness, or accident, and there is an operating theatre where even the poorest monkey may be operated on for appendicitis, or a hastily swallowed thimble." All are willing to admit that the animals in "The Zoo" are entitled to what has just been narrated, and yet it is a known fact that the same cannot be said about humanity in general. In our larger cities, hospitals, dispensaries, etc., etc., together with perhaps the larger percentage of physicians, many are trained and qualified to meet the conditions in cases of accidents of all kinds, whether there is an emergency issue or not. But this is not true of some whether practicing in the city, or suburbs. For the latter class especially, has the writer prepared this paper, from practical experiences as he has met them.

There is neither reason, nor excuse for the lack of preparedness, to say nothing of the lack of intelligence of some of our professional brethren in reference to the subjects of this paper. The writer has no thought of presenting anything new or original, but of calling attention to the fact that every M. D. ought to possess all the "knowledge, nerve and activity" to either properly treat, or direct the same in the class of practice under consideration. Every practicing physician owes it to the public to keep so informed, and it is not difficult to do so.

A friend, who is "making good" in business, handed me a pamphlet from which I took the following:

"We like to see people pleased. When they buy a thing it is a pleasure to see them more and more satisfied the longer they possess it. Every man ought to have a good ———, and every man intends in his heart to have one some day. There are few things so deeply and perpetually satisfying to a man as a good ——— that, by its very performance day and night, earns that intimate respect and confidence, which is given to no other inanimate possession. It is an important part of every man's personal equipment—his close companion. He relies on it to guide his movements. Since it is carried so long, is so desirable, in fact, so indispensable, and if a genuine one, is a thing of beauty and a joy forever, therefore, so seldom purchased, it should be secured from one who has a thorough knowledge, and is a fair dealer. A ——— is not a piece of mere merchandise to us. It is a living, pulsating thing, ——— an example of the most exquisite handicraft of human ingenuity. It must fulfill the function for which it primarily exists."

Instead of presenting to you a series of stereotyped statements from surgical text-books, we will present a number of cases, in which the terms, accident and emergency played their part. These are cases that are likely to need the services of a doctor at any hour of any day, and a cursory reading of the above pamphlet will point its own moral. It is true that considerable training and skill are sometimes needed, and they should be acquired, if not possessed. If it is possible to make a diagnosis of dislocations or fractures when first called, do so with or without an anesthetic. It is not only a waste of time and effort, but it is adding insult to injury to attempt to replace a dislocated bone, or set a fracture unless it is a very simple one, or the patient is not nervous, nor suffering great pain, without an anesthetic. The writer has had splendid success with Squibb's chloroform judiciously administered.

CASE I. Mrs. R. About 11 P. M., while going down stairs, slipped and fell headlong, striking left side of face, and left shoulder on each step until she reached the floor below, where she lay stunned for quite a while. Realizing that she had been injured the writer was called in, and, after careful examination, diagnosed a subcoracoid dislocation of the left humerus; face bruised, and other bruises about body. On account of the great pain, and her extreme nervousness, I ad-

ministered chloroform, and reduced the dislocation. Suitable dressings were applied, and arnica 1x given. Prompt and satisfactory recovery took place.

CASE 2. Man; age 42. Hernia, entero-epiplocele, right side; scrotum and inguinal region bulging with the mass. Had been extruded for some hours, although patient did not complain of much pain. He had been making efforts at reduction himself off and on for hours. With the patient in the supine position, and his limbs slightly flexed, manipulation of the mass gently, but firmly and continuously for a short period gave us splendid success, the mass slipping back with a slight gurgle. An examination of the mass at first led me to think it might not be replaced without a major surgical operation.

CASE 3. Child; age 5 years. Hernia, right oblique enterocele. While romping about the street at play he ran in the house, crying about a pain in his right inguinal region. His mother brought him to my office. Placing him on my surgeon's table and examining the parts carefully, I found a large mass filling the right side of the scrotum and extending into the inguinal region and into the abdomen. After considerable difficulty, owing to the pain and nervousness of the child, together with the size of the mass, it was finally reduced with a distinct gurgle. A Z. O. adhesive dressing was applied and a truss ordered. It is by no means a simple act to reduce a hernia. In some cases but a small section of gut protrudes from the abdominal cavity; in others a very considerable portion of gut and in others either a mass of omentum, or omentum and gut. These may or may not be partially or completely strangulated, and many complications are likely to be present, or arise. Therefore, a correct diagnosis should be made, and when reduction is attempted, great care and an abundance of patience exercised, so that your manipulations will not injure and jeopardize the gut, and the patient's life. If an anesthetic has to be given, one should be especially guarded not to persist too long in the attempt at reduction, nor in any sense rough in his manipulations. The number of cases of hernia in all ages and in both sexes certainly suggest the wisdom of possessing sufficient knowledge to know what to do and how to do it, for it not infrequently happens that herniae occur at most inopportune times and places where special surgical skill is not at hand.

CASE 4. Mrs. R. T.; age 43. When housecleaning and while moving about some furniture, ran a needle in her middle



finger, breaking the needle and leaving a portion of it in the palmar side of the distal phalanx. Her hands were much soiled at the time; crying out with the pain, her mother coming to see what the matter was (with soiled hands) attempted to remove it, which she succeeded in doing after working at it for quite a while. I was 'phoned for, but was out and did not arrive for several hours. In the meantime her mother had her place her finger in a cup of strong phenol-sodique up to the second joint. When I arrived I found the finger swollen, tender and with a peculiar look to it. Although the patient and her mother believed the accident of the needle's penetration was the cause of the suffering and what was thought to be necessary for some weeks, the amputation of the finger, as a matter of fact the accidental circumstance of immersing the finger in the phenol-sodique for so long a time caused such a profound and distressing burn and devitalization of the finger that it will be deformed and a less useful member for years. It took the most skillful kind of service to save the finger at all. There was no suppuration where the needle penetrated, but the skin and flesh seemed to have been boiled to death, and all because of the wrong treatment by her mother, when she thought it was the best thing to do. In this case, as in many other cases where needles or pieces of steel enter the fingers or other parts of the body, all that is needed is cleanliness of the parts, and perhaps a simple antiseptic dressing for a day or so. The writer prefers dry dressings as a rule. When other kinds of foreign bodies, or matter enter any part the above advice does not hold good. Free incision, the positive removal of the offending matter, and as a rule the curettage of the part with or without the free use of carbolic acid pure, bromin solution, or if the case was not likely to become septic, calendula is a great favorite with me. Any antiseptic agent or wet or dry dressings may be used according to the experience or fancy of the doctor. Pure, strong alcohol is a good and safe one in many cases, and can be had quickly. In this case, as in all cases, wherever a homœopathic remedy is indicated, or wherever it is believed it can be of substantial value, it is prescribed and in any potency.

CASE 5. C. H.; male; age 42. Man scratched his left index finger on a piece of rusty tin; his hands soiled with earth; at the time he did not pay much attention to it, but in a few days the pain and stiffness led him to paint it with iodine. This did not improve it, so he called in his family physician. He

ordered poultices for a number of days. These did no good. The finger had by this time become swollen to a diameter of about one and one-half inches, and the man getting weaker, and suffering agonizingly, the writer was called in and decided that the case was one of profound streptococcic infection. A free incision from tip to end of finger on palmar side, and a free incision on the dorsal side of about an inch revealed bare bone, infected tendons and a finger hopelessly diseased. Every effort was made to limit the infection to the finger but without result, so that we amputated the finger and then had a fight for weeks not only to save his hand, but to save his life. The infection, virulent and relentless, pursued its course in spite of the free incisions, free use of the most powerful antiseptics for a number of weeks, when, after a thorough curettage and the free use of bromin solution and suitable antiseptic dressings, we succeeded in our efforts. The man is now greatly improved in health, and the hand almost healed. Besides bromin solution, pure carbolic acid, bichloride solution, Burrow's solution, and other solutions were used, but the bromin solution seemed the more potent one. The infection in the palm was severe, and difficult to control, the infection in the tendons being especially rebellious. In this case a simple incision and free use of carbolic acid, or bromin solution would have stopped the infection had it been done when the doctor who was first called in known enough either to have done it himself or called in some other competent doctor *at once*. Anesthetize if necessary. There is but one successful method of treating these infected cases, the result of accidental circumstances, no matter how apparently trivial. *Early and free incision*, together with some of the antiseptics mentioned above will limit the process if intelligently applied. If not seen early, then heroic means should be used, and continued; amputations should be done where a member seems hopelessly infected, the infection spreading to distant parts and deeper structures, and the constitution visibly affected. Here the patient needs the best possible nourishment, suitable remedies, rest, and all the fresh air and all the encouragement possible. Anesthetics should be used sufficiently often in the re-dressings to give the doctor a proper chance to do *all* he should, and to save the patient pain and mental distress. Tonics and stimulants and such other emergency measures as are

required in individual cases. Echinacea, arsen., chinin-arsen., etc.

CASE 6. Baby; 18 months. Grandfather had her out in little coach which was overturned, throwing child to pavement, and striking child's head. When called in the child had convulsions. It was a very hot day, and whether the fall, or the heat was responsible for the convulsions we did not know. We examined the child carefully, but found no injuries other than a slight bruise. As the child was unable to swallow at the time we first saw it, and having a little chloroform with us, and the convulsions being severe, the child seemingly near death, we concluded to let it inhale a little chloroform. To our great satisfaction it broke the convulsion, even though only a small quantity had been used. We were then able to give belladonna, as it was clearly indicated according to such symptoms as we had to guide us. The child rapidly improved, and no other convulsions followed that night or the following day, when last we prescribed for it. We believe the chloroform exerted a therapeutic effect.

CASE 7. Woman about 30. Abortion. Pregnant about three months. Fell off a step-ladder, while house cleaning, striking on her hips; followed by pain in uterine region, and soon after profuse hemorrhage. When we reached her, she was in a state of collapse from loss of blood. A speedy examination was made, and an equally speedy emptying of the uterus, under strict antiseptic precautions, was done. The woman had fainted and continued in such a critical condition for a number of days, that we almost despaired of saving her life. However, she made a splendid recovery. The quick recognition of the cause of her condition, and the prompt treatment alone saved her life. To have hesitated, or to have done less would have robbed a home of a wife and mother. When I first saw her she was lying in pools of blood, and in a collapsic condition. Although we had to operate under such circumstances there was no infection. Notwithstanding it is the teaching of some authorities that the uterus should not be curetted for abortion cases until after the third month, the writer follows the plan of making sure the uterus is thoroughly cleaned out and hemorrhage controlled in every case no matter what the period is. Gentle curettage with a free mopping with iodoform gauze will never do any harm to any uterus, and it is the safer plan, as an experience of a score of years proves. Such



tamponing as is necessary, for a day or two generally suffices. If the case is not septic, but few uterine or vaginal toilets are necessary. In septic cases irrigations, moppings, applications and tamponings may be necessary for a number of days. As these cases in practice are by no means uncommon, and often the result of accident, the emergency character of the case and prompt service are the order of the day. Of course, no uterus is emptied if there is the slightest possibility of saving the foetus. Homœopathic remedies are usually given, and often with satisfactory results.

CASE 8. Woman, 36. Placenta prævia. Nearly seven months pregnant. Fell down cellar steps. Shortly after had profuse hemorrhage from vulva. Speedy examination revealed placenta presenting, and apparently implanted in lower uterine segment. We secured assistance, and had her anesthetized, and under strict antiseptic precautions, carefully emptied the uterus. As there was some dilatation already, we further dilated with our fingers, and as rapidly as we could delivered the placenta and the foetus. The hemorrhage after the uterus was emptied was controlled by packing the uterus with ice. No infection followed, and the woman who was almost exsanguinated, made a quick and splendid recovery. She has since given birth to a fine boy in a subsequent pregnancy. In this case to have used ergot or some other drug to control the bleeding, or even to have tamponed, would have been to have lost both mother and child. Of course, the foetus was dead before delivery. When we operated this case we informed the patient and her husband of its gravity, and before we began the operation, she had her priest give her the last rites of his church, as he told her she could not recover.

CASE 9. Mrs. M.; age 58. Urethral calculus. Was called in hastily to see this woman, who said she had severe burning pains in the urethra; difficulty in passing urine, and soreness at mouth of urethra. These symptoms led me to prescribe cantharis 2x. In less than two hours I was again summoned, and found her in agony, all bent double, and complaining bitterly that the medicine did no good. Between her complaints she took time to tell me that she thought something was protruding from the urethra. Although she at first objected to an examination, I found on examining the parts very carefully a firm mass seemingly impacted in the urethra. We could not move it at all for a while, and any attempt to do so caused ex-

cruciating pain. Finally, I told her she would have to permit me to remove it, and as she had advanced parenchymatous nephritis, we could not use an anesthetic, so by insinuating one finger along the vaginal side of the urethra, and with several fingers of the other hand I succeeded in teasing it out. It proved to be about the size of a peanut, and rough and hard. Aside from the soreness and local inflammation for several days all pain ceased and she could urinate easily and painlessly.

Look what inspection and instant manipulation did here. How many doctors take time to inspect the various exits of the body? We have tried to show by some of the cases reported to you, where not medicines were needed alone, but emergency treatment. It is always safe and sane to look, or at least feel.

CASE 10. Miss B. G.; aet. 16. Dental caries. This girl had been to a well and favorably known dentist to have a tooth treated. It had abscessed, and his manipulations about the tooth had broken it off. The suppurative process went on, and he failing, told her to go to her family physician. This she did for a number of days, and he poulticed it. More and more rapidly it swelled until she hardly looked human. Then he sent her to one of the largest old school hospitals in our city. She was there a number of weeks and, not improving, the family were becoming distracted. Although they were bitter against our school, they came and pleaded with the writer to take the case. What should I do in the matter was a question of no small moment. A skillful dentist, a successful O. S. physician, and the surgeons in a prominent hospital all failing, and then coming to a despised homœopath. How's that for nerve? Well, we told them if they would give us the right of way to operate, as we were led, and to absolve us from all blame, in case we were not successful, we would attempt it. We did so, and successfully. After having her anesthetized, we carefully cut down along the inner side of the right jaw, and probing found necrosis of the external plate of the jaw bone from the chin to the articulation. This necessitated a free incision outside, but not as long as inside. We removed all dead bone we could, curetted all else and packed with iodoform gauze. Although we could pass our finger from outside to inside of cheek, and although she was profoundly septic for a number of days, she made a complete recovery, leaving only a small scar on the under side of the jaw.

The death of one of our city's wealthiest women recently, from a similar condition to the one recited above, and who was attended by some of the most noted O. S. surgeons, led to the presentation of this case. Many a person has an alveolar abscess, and either does nothing but poultice, or goes to a dentist or physician who is often not competent to operate, or hesitates about doing so. Many fatalities, and many more marks and scars are in painful evidence of the need of skillful and prompt service in this class of cases. It is a surgical axiom, that where pus is believed or known to exist, to have it evacuated at the earliest possible moment, at the most dependent point compatible with the anatomy of the part and the advantage of good drainage.

Many cases of threatened or beginning abscesses about or in the teeth can be quickly cured by the administration of mercurius or hepar. We have done so a number of times. As stated in the beginning of this paper, the writer, after repeated requests from the genial and courteous chairman of the Surgical Bureau, agreed to attempt to present a paper of practical value to the greatest number of general practitioners, members of our society, and not one for surgical specialists. Many other cases of accidental nature requiring immediate or emergency treatment could be cited, but this subject is a large one and this article is suggestive and not conclusive.

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APPENDICITIS IN CHILDREN.—H. Salzer comments on the high mortality of appendicitis in children (*Weiner Klin. Wochen*, May 18). Kummell cites it at 11, 19 and up to 30 per cent., and in Salzer's 200 cases, thirty-five of the children were apparently cured in internal measures alone, two were moribund and 163 were given operative treatment with twenty-two deaths, a total mortality of 12 and operative mortality of 13 per cent. He insists that this excessive mortality is due solely to the fact that the trouble is not recognized early enough. People are too apt to regard gastro-intestinal disturbances in children as a matter of course and not as frequently a symptom of a serious affection. An early operation should be recommended even more energetically than for adults.—(*Med. Rev. of Rev.*)



## EDITORIAL

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### THE DOCTOR AND THE MEDICAL JOURNAL.

IN a recent issue of the *Wisconsin Medical Recorder*, Dr. George L. Servoss has called attention to the value of the medical journal to practising physicians. Dr. Servoss introduces his subject by stating that "The medical journal, be it of the organization or the independent type, is of vast service to the doctor. It is to be admitted that probably there is much published in all journals which is practically worthless, but, on the other hand, one cannot con a single publication of this sort without he finds at least one article or item of worth. It may be some very little thing hidden away back in the miscellaneous column or it may exist in the advertising pages, but it is invariably there and he who goes carefully through every journal coming into his hands is usually the gainer."

There are probably few physicians who will take issue with Dr. Servoss' statement. In fact, if one is desirous of keeping his medical knowledge up with the times he must, of necessity, rely upon the medical journals for his information.

It is a well recognized fact that the larger part of our textbooks are antiquated soon after their publication, and even the best of them are a year or two behind the times.

The more intelligent laymen are quick to recognize the superior value of the services of the up-to-date physician and are, therefore, likely to prefer the man who keeps abreast of medical thought by subscribing for and by reading the representative medical journals.

Dr. Servoss relates an instance that came under his observation which well illustrates this point:

A stranger coming into a town and requiring the services of a doctor went to the postmaster and asked which physician in town received the most medical journals. When asked why he desired such information and subsequently visited that particular doctor his reply was, "The doctor who reads the most journals undoubtedly gains something from each publication and

consequently is more liable to be the best posted man in the community, professionally."

We desire to emphasize another relation that every medical practitioner should sustain toward the medical journals of his school, and that is as a contributor. It is true that many an excellent practitioner is not a literary genius, but it is also true that every physician in the practice of his profession meets with experiences that are of interest and value to his professional brethren. Such experiences, briefly and plainly stated, constitute valuable contributions to medical literature and in practical value may far surpass elaborate literary productions. Aside from the value of such contributions to the profession, they are of inestimable value to the physician himself. They develop his powers of observation, they increase his facility for stating his ideas and broaden his whole interest in medical science.

In our own school of medicine contributions from general practitioners bearing on the symptoms produced by the accidental administration of drugs in toxic doses, corroborations of clinical symptoms and brief but accurate statements of cures brought about by the influence of the indicated remedy, form invaluable contributions to our literature.

The pages of the *HAHNEMANNIAN MONTHLY* are always open to articles of this nature from legitimate physicians and we are desirous of giving every possible encouragement to such work on the part of older practitioners or of younger men who have the time and opportunity to make such contributions.

To those who are not accustomed to preparing articles for publication in medical journals we would offer the following suggestions; The facts should be stated in the fewest possible words and in the plainest language. The essential facts should be stated accurately and the practical deductions drawn from them should be plainly set forth. Long theoretical discussions and elaborate compilations from other writers should be studiously avoided by the novice. Such material is suitable only for articles of a highly technical character, written by experts. In fact, even experts would do well, as a rule, to avoid such matter as far as possible. for the day is past when the busy physician was able or willing to spend his time in wading through voluminous monographs.

It is our hope that every reader of this communication will consider it as addressed to himself personally and that it will be of value to him in assisting him to make better use of this

and of other medical journals and will inspire him with the purpose to make such contributions to the literature of our school as his time and opportunities will permit.

G. H. W.

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### INDISCRIMINATE DRUG TAKING.

WHEN we go into the histories of the patients who consult us it is surprising to learn what a large percentage of them are in the habit of taking, more or less regularly, poisonous drugs that have been recommended to them through the medium of the advertising columns of our newspapers and magazines or through the mistaken kindness of friends. Not only is this the case among the less intelligent people but it is surprisingly true among those who have had the advantage of a good education.

Did the public but realize that the vast majority of drugs are poisonous substances which tend to derange the normal processes of the human organism, they would probably hesitate before introducing them indiscriminately into their bodies.

While the American people in particular have always been addicted to the "medicine habit," such a habit has become much more dangerous than in former years, owing to the fact that the various herbs and bitters so popular twenty-five years ago, were in the main comparatively harmless though often useless, while the modern synthetic drugs, made from coal-tar and other substances, are extremely injurious to the human organism, especially if used over an extended period of time.

The laxatives and purgatives are the most commonly abused of any class of drugs. Personal investigation has revealed the fact that fully fifty per cent. of patients applying for treatment, who have been brought up in the old-school medical ideas, are habitual users of laxative and purgative medicines. Cascara, sagra-da, aloin, the various patent "vegetable laxatives," Epsom salts and the various laxative mineral waters, are the substances most commonly used. The effect of the constant use of these drugs cannot be other than detrimental to the normal activities of the gastro-intestinal tract. But aside from the actual deleterious effect of the drugs themselves, harm results from the fact that the causes underlying the constipation are entirely



neglected owing to the temporary relief obtained from the laxative drug.

A normal individual getting the proper amount of exercise and eating proper food should not be constipated. The development of the constipated condition is the result of some well-defined cause, which may be bodily inactivity, improper diet or some functional or mechanical disturbance in the gastrointestinal tract. The rational management of such a condition would be to correct the underlying cause and not to mask it by the habitual use of a laxative which ameliorates the symptom but does not remove the causative factor.

Headache powders are another class of drugs that are very commonly abused. These remedies are widely advertised in the newspapers, magazines and in the windows of drugstores. The average individual finds it much easier to resort to these palliatives than to make such regulations in his habits as would result in a subsidence of the headache. Unfortunately, drugs of this kind are dangerous, not only because of their immediate effect as a cardiac depressant, but because of their ultimate effect in producing a deterioration of the red corpuscles of the blood with the consequent impairment of nutrition. We have all seen the victim of the acetanilid or phenacetin habits, with his bluish-white color, his pinched features and his irritable mental state. The victims of this habit are becoming more and more common and it is the duty of the physician to warn their patients of the dangers resulting from the indiscriminate use of such remedies.

Another class of drugs that are commonly used by the laity to-day are the so-called "uric acid remedies." The public at large have become so saturated with "uric acid" that the advertising quack finds a very fertile field for his activities in this direction. The number of diseased conditions that are traced to uric acid is legion. In fact there is scarcely a disease in the whole category of human ailments that charlatans do not attribute to either "catarrh" or "uric acid." The medical profession has been to blame for the propagation of the ideas regarding the relation of uric acid to diseased states. It seems unfortunate, however, that at the time when the uric acid idea has been entirely exploded that the public should be so zealous in taking it up to the detriment of their health and to the benefit of the advertising quacks.

Another prolific source of revenue to advertisers of fake

cures is the very common backache or lumbago. Such a symptom, which is usually a comparatively trivial one, is widely advertised as an infallible sign of Bright's disease, and the innocent sufferer usually hastens to invest in a large stock of kidney pills and other abominable concoctions that are stated to be a sure cure for Bright's disease. Many of these mixtures contain substances that are distinctly irritating to the kidneys and their constant use is well calculated to produce the very disease that they are presumed to cure.

We might continue this subject indefinitely did we choose to comment on the various mixtures swallowed by the gullible public for the cure of female disorders, nervous prostration, insomnia, lost manhood and a hundred and one other disorders the majority of which are more imaginary than real. It is sufficient to say, however, that as a general rule, indiscriminate drugging on the part of the layman is frequently harmful and usually useless; it tends to the production of drug habits; to the development of functional and organic disturbances in a previously healthy body and to the loss of valuable time and money which, if devoted to proper treatment under the advice of an expert physician would save much distress and suffering.

G. H. W.

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**TUBERCULOSIS IN CHILDREN.**—The intracutaneous tuberculin test is considered by the author to present many advantages over other diagnostic tuberculin reactions. It is relatively easy to carry out, the result of the test is readily recognized, and the discomfort to the patient minimal. The amount injected can be accurately gauged. The possibility of injecting different strengths and even a high concentration of tuberculin by this method renders the test available in all cases of tuberculosis. The subcutaneous tuberculin test fails in patients with fever, while the cutaneous reaction fails in cases where the susceptibility of the organism to tuberculin has been reduced through acute infections or cachexia; the intracutaneous method, on the other hand, succeeds in all these cases. It is true, in many instances, the only procedure to be depended upon. In patients morbidly in dread of tuberculosis, this test, if strong concentrations of tuberculin cause no reaction, will definitely eliminate any possibility of the presence of the disease. The case of a cachectic child with meningitis in which tuberculosis was ruled out by means of this test is cited by the author. He injects one drop of a 1:1000 solution of old tuberculin and, if no reaction follows, increases the strength to 1 per cent., 10 per cent., and even sometimes 100 per cent., some cases finally reacting to the last-named dose.—Engle, *Deutsche medizinische Wochenschrift*.

## GLEANINGS

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**TUBERCULIN TREATMENT.**—The opinion now is that tuberculin acts in two ways: (1) By giving rise to immunization processes and (2) by causing the so-called area reaction—but the relative value of the two processes is still in dispute. The estimation of the sensitiveness of tuberculin by the reaction to von Pirquet's and the ophthalmic test in tuberculous patients does not, in the opinion of Sorgo and Suess, form a guide to prognosis, nor does the sensitiveness, as shown by the extent of the general reaction. In patients, however, who have already had large doses of tuberculin, a sudden rise in sensitiveness to tuberculin seems to be of unfavorable prognosis and there is often a lasting intolerance to tuberculin and a rapid progress of the disease. There does not seem to be any constant relationship between the intensity of the area reaction and the intensity of the reaction to von Pirquet's or ophthalmic test. The two great methods of administration of tuberculin are those of the repeated administration of minimum doses, the anaphylactizing method and the administration of gradually increasing doses—the immunization method.

Until recently the latter method was practically the only one in use, and whatever may be the theoretical objection to it, it has proved practically useful. The other method is now frequently employed. Escherich has found it especially suitable for young children, and it is often the only possible method, because the patient can not bear any increase of the dose. The form of tuberculin administered does not seem in most cases to be of great importance if the precaution of using the more toxic forms only in large dilutions is taken. T. R. and the bacillary emulsion are, however, the forms best borne by patients with fever, while if Bandelier's observations be correct, bacillary emulsion may be harmful in laryngeal tuberculosis, and should be employed only with caution. An initial dose which may be tried by inexperienced persons is 0.000001 gram, or 0.00001 gram. With experience the operator may in suitable cases begin with a larger dose 0.0001 gram. The severity of the cutaneous reaction is of some service in fixing upon the initial dose, but taken alone it does not give a certain indication as to how much tuberculin will be tolerated, if however, a cutaneous reaction is present when a small dose is given and absent when the same dose is repeated, the dose may be safely increased, while in cases of excessive cutaneous reaction it is perhaps advisable not to increase the dose. Small hemorrhages from the lungs do not absolutely contra-indicate tuberculin treatment; nor heart affections, though when the cardiac muscle is much affected and subjective symptoms follow an injection, the treatment should be discontinued. Injections should not be given in the case of women during the menstrual period. Patients with fever, or in very poor general condition, those who are very nervous, who suffer from heart disease, or from a tendency to hemorrhages, are to be considered unsuitable.—*British Medical Journal.*



THE INVESTIGATION OF HEART DISEASE.—Dr. L. F. Bishop in the December issue of the *Medical Review of Reviews*, describes in detail a very satisfactory routine method of examining patients suffering from affections of the heart.

Dr. Bishop states that the first procedure in encountering a new patient is to find out in a general way what the patient's most prominent symptoms are and then it is well to talk to the patient a little while, become acquainted with him and gain his confidence. It is a good plan with most patients to let them have their say out, as it were; that is, let them say as much as they like before you feel that it is time to interrupt. In other words, it is a good plan to let a patient tell his own story before you have prejudiced him by asking questions. You can unconsciously force a great many people to tell you a story about themselves that has had its origin in your own imagination, so be careful to elicit all the spontaneous information that the patient will give you before you question. When you do question the patient go back to the very beginning.

Try to get the family history and the patient's history as to previous attacks. In cardiovascular disease you ask about rheumatism, typhoid fever, St. Vitus' Dance, and such other diseases as may have caused some acute inflammation of any of the heart structures. You also ask the patient particularly about pain, and in recording pain the diagrams are very useful.

In the early part of taking a history it is best to keep as far as you can away from the present illness. Get the family history, the previous history and all the outstanding information, keeping away from the present illness. Then take up the present illness and try to pin the patient down to definite symptoms. The symptoms of patients are of course, limited by the patient's memory and by things which he knows. A great many people in general have not a good memory for the time of occurrence of things and they are prone to forget many points that have not made an impression, and you have to refresh their memory and pin them down.

The onset of a condition is not always easy to describe or for the patient to fix, and my own custom is to ask: "How long have you been sick?" then follow that up by another question: "Were you perfectly well up to this time?" The second question generally elicits information going back to that received by the first question.

In heart cases the onset is often very sudden and can be definitely fixed; that is the case, of course, where there has been a severe infectious disease leaving the heart crippled; it is true when some accident has happened like the rupture of a valve or an acute dilatation.

In other cases, however, the onset is gradual. The degenerative heart cases develop their symptoms gradually, the progressive shortness of breath, the appearance of a little edema and so on.

You remember the great emphasis that I laid upon the cases in which there was a definite failure of the functions of the heart, and the cases in which there was not. The cases with a definite failure of functions show three cardinal symptoms, viz., shortness of breath, swelling and tenderness of the liver and edema.

Other symptoms of heart disease, leaving out the cardinal ones, are,

viz., palpitation, pain and the objective signs. Irrespective of this division of functional incapacity and cardiac disease in general the symptoms to be elicited are pain, dyspnoea, cough, palpitation, fainting attacks and digestive disturbances, mental changes, loss of flesh and dropsy.

I am disposed to classify pain in cardiac disease under one heading and record it as cardiac pain, bearing in mind the possibility of acute inflammation, as a reflex pain derived from the heart muscle.

I am not disposed to divide cardiac pain into any hard and fast classification. I never use the term *angina pectoris*, nor *pseudo angina*, nor any of those names. I think of cardiac pain, as far as I have been able to analyze it, as having its origin in the heart muscle and varying according to circumstances. I have never been able to divide my cases. Of course, as a matter of clinical convenience, we can place in the category of *angina pectoris* severe cases of heart disease characterized by pain and associated with arterio-sclerosis.

The next symptoms to investigate are shortness of breath and cough. The characteristic shortness of breath in heart disease is that it occurs on exertion, while in other cases it may be pretty persistent all the time, or it may come in paroxysms. The shortness of breath on exertion is more suggestive of simple cardiac failure. The form that comes in paroxysms is more characteristic of cases secondary to arterio-sclerosis, and cases involving the kidneys. Persistent shortness of breath is, of course, a bad sign and means that the heart has in a pretty definite measure failed in its power to work.

Cheyne-Stokes breathing has been variously explained, and it is always a very serious symptom. It would appear that it is due to exhaustion of the respiratory center, or at least that it was occasioned by a respiratory center poorly supplied with blood. It has always seemed to me in watching a case that the respiratory center did not respond to stimuli; that the patients did not draw a breath when they were a little short of air, or that they would draw a breath after the lungs had become very badly supplied with air, and that the respiratory center being once set in motion had worked over-time, and the patient took a number of quick breaths till the lungs were over supplied with air and the center was exhausted and then there was a pause, and the same thing repeated itself.

Palpitation is a subjective and an objective symptom which you should always record in cardiac cases, and it is particularly important because the patient may be able to recall palpitation extending a long way back previous to the time he consults you.

Fainting does occur in heart disease, but is not a usual symptom in organic cases. A curious variation of fainting is the epileptic cases that are quite characteristic of Adams-Stokes' disease. The digestive disturbances should always be looked into, because they are somewhat dependent upon chronic congestion of the digestive organs, and then they often throw light upon the origin of many cases of myocardial disease and arterio-sclerosis. It has seemed to me that a very large proportion of such cases had their origin in intestinal toxæmias.

There are no mental disturbances in young people with cardiac disease, but in old people where they are combined with arterio-sclerosis, of course, mental disorders are more common.

An examination of the nutrition of the patient is very important because the progress of the case of cardiac disease depends just as much on nutritional conditions as the progress of a case of tuberculosis. Everything depends in a compensated heart case upon the maintenance of nutrition.

I have already spoken of the necessity of careful investigation for edema.

It is a good plan to always carefully inspect a patient. The cases of aneurism that can only be seen are not at all few, and by putting the patient where the light falls across the chest you can often detect a pulsation that you would not expect to find in that part of the chest.

An important method of examining the chest, too often neglected, is palpation. Put your hand over the precordial region of the heart, giving yourself plenty of time, and try to appreciate the nature of the heart that you are examining. That alone will very often give you a distinct belief that the heart is hypertrophied or that it is dilated; it will often give you a distinct impression of the forcibleness of the heart action. Then you try to locate the apex beat by palpation; this you cannot always do because the apex will not come to the surface, as in very stout people. The proportion of cases where you cannot locate the apex beat is quite large. Then you can use auscultation. By palpation you can also discover thrills, particularly diastolic thrills.

In percussion of the heart, do not forget the importance of having the percussing finger parallel with the line you are trying to locate. This is so common an error, or rather the contrary is, of putting the finger across the line, that I don't want you ever to forget it.

Then remember that until you become very skilful it is better to establish a standard of resonance (pulmonary) by, percussing some indifferent part of the lung and then percussing the area of total cardiac dulness. Auscultation involves a familiarity with the normal heart. The most important thing in auscultation is to go over the murmurs. Some of the more important points to remember are that the aortic murmur is usually not due to aortic stenosis. Cases of aortic stenosis are rare. Aortic direct murmurs are very common. They are found in a great many people who are suffering from arterio-sclerosis and are produced by a dilatation of the first part of the aorta. This aortic direct murmur is often heard pretty much all over the chest, and is not infrequently mistaken for a mitral murmur. You will be on the safe side if you do not hesitate to make a diagnosis of an aortic direct murmur in many cases of arterio-sclerosis where there is a pretty general murmur heard all over the chest, and a murmur that is not much louder at the mitral area than anywhere else.

The aortic regurgitant murmur is the easiest of all to hear and to diagnose.

Tricuspid regurgitation is not an easy murmur to identify. It occurs in so many advanced cases with dilatation and dropsy, and always in cases that have a loud mitral murmur, and is very often heard with a loud aortic murmur. In a case of dilatation of the heart with evidence of pulmonary engorgement and dropsy, if you hear a loud systolic murmur in this region, never mind how much murmur there is in the rest of the



chest, don't hesitate to diagnose a pulmonary murmur because it probably exists.

The murmur of mitral stenosis is a murmur of very variable quality and is a difficult murmur to hear and to analyze, and very often the belief as to the existence of mitral stenosis must not be a matter of physical diagnosis as much as a matter of judgment. If the heart is irregular, a tendency to fluid in the right chest, of pulmonary engorgement, hemoptysis, and a long history of mitral disease, it is fair to suppose that there is a mitral stenosis. Don't hesitate to make a diagnosis from inference without the murmur. The character of the apex beat is described as a "slapping" sound, and the existence of a thrill is also important.

FLATULENCE.—Burnet says that in most cases the diet will have to be carefully chosen and somewhat restricted. A rather dry diet will be found to suit best in nearly all cases—little liquid being allowed with meals. This excludes all soups and broths at the beginning of a meal and allows of only a small quantity of fluid toward the close of the meal. What the special drink should be has to be decided in each particular case. Some will do best with plain water, others may require a little stimulant—alcohol in some form.

Tea must be limited in quantity and must be freshly made. The stewed decoction called tea, so dear to the heart of the hospital out-patient, is a fruitful source of these digestive troubles and of the "spasms" so graphically described by the frequenters of hospital out-patient rooms. Distention and disturbances of digestion are not, however, by any means confined to the class of persons who come under treatment at hospitals, and as a source of flatulence the excessive use of tea amongst well-to-do people should be always borne in mind.

Animal food, is as a rule, best digested by these patients; it must be carefully selected and well, though plainly, cooked—under-rather than overdone; tender beef and mutton, chicken and other birds, game, and fresh white fish. Pork, veal, goose, duck, etc., should be forbidden. It will be often found best at first to limit the meat meals—luncheon and dinner—to practically one course, light tender meat and a little vegetable, with a biscuit and butter to follow. Much green vegetable will usually not be well borne, and what is given should be rubbed through a sieve—cooked as spinach is served. Often it is best to forbid potato for a time, and to substitute toast or second day's bread. Farinaceous foods have to be given carefully and the effect watched, but where digestion by the stomach is chiefly at fault, starchy foods, as they are dealt with chiefly in the intestines, may be given in greater amount. The contrary holds good where digestion goes on best in the stomach; then meats are most satisfactorily digested. Ripe fruits have to be taken in great moderation, and raw vegetables, salads, etc., are not usually allowable in the earlier stages.

Whether meat preponderates in the dietary or farinaceous foods, the absolute necessity for slow eating and complete mastication of all solids should be strongly and repeatedly impressed upon the patient. It is always well to ascertain the condition of the teeth, and not infrequently some repairs have to be carried out by the dentist before complete and comfortable mastication can be attained by the patient.

*Nux vomica* is one of the most useful remedies in these cases and it may be given in tincture, or in pill with a quarter of a grain of capsicum and a couple of grains of compound rhubarb pill. Bismuth is of use in many instances, with an alkali such as bicarbonate of sodium, and calumba or other bitter infusion.—*The Practitioner*, October, 1911.

**PITUITARY EXTRACT.**—Parisot and Spire (*Annales de Gynecologie et D'obstetrique*) as the result of their own experiments and those of many other investigators, affirm that while the extract of the pituitary gland increases the blood pressure and the arterial tension, its action is less intense but more prolonged than that of adrenalin, and is accompanied by slackening though strengthening cardiac contractions, its influence extending also to many other organs. Pituitrin, the extract from the posterior lobe of the pituitary gland, excites moderately the muscles of the bladder and very considerably those of the uterus, and its action is much more marked upon the gravid than the nongravid uterus. In regard to the toxicity of the extract, it is agreed that it is less toxic than adrenalin; and in no case have the many investigators observed any toxic effects, or local irritation at the point of injection, and the contractions never have a tetanic character. Clinical observations show that in a majority of cases the pituitrin tends to arouse and reenforce the uterine contractions and to reduce the duration of labor, though in some cases it had no appreciable effect. It was administered sometimes by the mouth, more generally by injection either subcutaneous, intramuscular, or intravenous, the latter method, by injection, being apparently the most effective. In cases in which the induction of labor before term was indicated, some obstetricians have tried to induce labor by the use of this extract alone, with success in two cases out of three. It has also been employed, generally with some advantage, in cases of uterine atony and post partum hemorrhage. But the authors consider that it should never be used unless the patient is free from albuminuria, any unusual arterial tension, or symptoms of eclampsia. The use of this extract in cases of abortion, to hasten the expulsion of the dead fetus, has been tried but without encouraging results. Because of its effect upon the bladder it has been used to combat the retention of urine after or during labor, with favorable results. The results obtained by French obstetricians have been less satisfactory than those reached in England and Germany. This, it is suggested, may be due to the fact that the French have used the extract of the whole pituitary gland, while the English and German investigators have used that of the posterior lobe alone, having thus a stronger dose, which the French purpose to employ in their further investigations.—(*Medical Record*).

**THE CAUSES OF ASCITES.**—Cabot, has made a study of 5,000 cases. The actual causes of ascites are tabulated, as follows: (a) Causes of ascites as found post mortem in 2,217 autopsies from the records of the Massachusetts General Hospital; (b) as observed clinically in 3,086 cases during the last forty years at the same hospital; and finally (c) a tabulation of the *rates* at which ascites accumulates in different diseases (valuable as an assistant in identifying through its more or less char-

acteristic *tempo* of accumulation the ascites of tuberculous peritonitis). Post mortem examination revealed the following as some of the causes, in order of their frequency: Cardiac weakness, nephritis, abdominal neoplasms, cirrhotic liver, and tuberculous peritonitis. In the clinical statistics of ascites, the diagnosis was verified either by operation or autopsy in all cases of neoplasms and thromboses and with most cases of intestinal obstruction and tuberculous peritonitis; but in the cardiac, renal, and hepatic cases and most of the blood diseases the evidence is wholly clinical. These statistics follow closely those of the first series as to relative frequency. The following are points of interest in this view of the subject: (a) The frequency of ascites with ovarian cysts and tumors, and (b) the large figures obtained in intestinal obstruction (the fluid in these cases may have the result of an actual peritonitis associated with the obstruction). The rate of ascitic accumulation was studied in forty-nine cases with the following daily results: Cardiac weakness, 36 to 54 ounces; cirrhosis of the liver, 20 ounces; nephritis, 13 ounces; solid ovarian tumors, 12 ounces; neoplasms of the abdominal organs and glands, 11 ounces; adherent pericardium (before cardiolysis), 11 ounces; same (after cardiolysis) 2 ounces; uterine fibroid, 8 to 11 ounces; tuberculous peritonitis, 5 to 6 ounces. In the different varieties of ovarian tumors ascites occurred in fibroma, 50 per cent.; carcinoma, 40 per cent.; sarcoma, 20 per cent.; cystoma, 7 to 9 per cent. In none of the fourteen cases of parovarian cyst operated on was ascites found. The writer concludes his study as follows: 1. Among the possible causes of extensive ascites we must not lose sight of the small solid tumors of the ovary. 2. Pleural effusion may be produced by an extensive ascitic accumulation. This association may lead to a false diagnosis of pleural and peritoneal tuberculosis. 3. The cure of both pleural and peritoneal effusions may result from excising a benign tumor. 4. Among all causes of ascites tuberculous peritonitis may sometimes be recognized by the greater slowness of its accumulation of fluid. 5. Intestinal obstruction ranks fifth, and diseases of the female genitals sixth among the causes of ascites, being surpassed in frequency only by cardiac disease, nephritis, cirrhosis, and tuberculous peritonitis. 6. Beside the causes just mentioned, abdominal neoplasms and adherent pericardium are the only factors of importance in the production of ascites.—(*Amer. Jour of Med. Science*).

CANCER OF THE RECTUM.—Mummery (The Lancet) observes that by far the greatest number of cases have the growth at the very worst point for treatment, that is high up, involving the peritoneal cavity. With regard to age incidence, he believes that statistics are misleading and that in general the disease is most frequent between fifty and sixty years rather than earlier, as is commonly given. The male sex is also slightly more commonly affected than the female. The one most important predisposing factor is the occurrence of a simple benign growth such as polypus or simple adenoma. Multiple polypi of the colon are likewise frequent precursors of malignant disease of the rectum. In the rectum as elsewhere the cancer spreads by way of the lymphatics and by direct extension to the neighboring tissues. Metastasis does not occur early, though when it



does appear it is usually to be found first in the liver. The disease, particularly in its early stages, when surgical interference gives the best results, unfortunately causes no symptoms of importance. Cancer of the rectum is, in fact, not incompatible with perfect health for a long time and until it has become very extensive in its development. The "textbook symptoms" appear only in the later stages. The most typical early symptom is a slight diarrhea which is spurious—that is only a small amount of material is expelled at one time, though the patient has to move his bowels frequently. There is often only a little mucus which may be blood stained. Exercise and meals bring on the diarrhea; the call to stool is so urgent that the victim is often afraid to go far from some place of relief. It is Mummery's opinion that any person presenting this symptom of diarrhea should be examined rectally for the possible presence of an early cancer. Pain or discomfort in the sacrum is also quite common and it is characteristic that the pain is not relieved, but increased by recumbency. No differential diagnosis is necessary between benign and malignant growths of the rectum, for in any case of neoplasm here surgical measures are essential if the condition is not too far advanced. The differentiation may then be deferred in difficult cases till the patient is under the anesthetic. There is but one form of treatment and that is radical removal of the growth and all infiltrated or neighboring tissue. Mummery finds a combined abdominal and perineal operation is the most satisfactory in all but the lowest cases. The prognosis is less unfavorable than would be imagined, for early complete excision gives a good prospect for complete freedom from recurrence.—(*New York Med. Jour.*)

NOGUCHI'S CUTANEOUS LUTIN REACTION.—Cohen says that, working on theories borrowed by von Pirquet in the discovery of the cutaneous tuberculin reaction, Noguchi has employed a theoretically analogous method as a test for syphilis. The test emulsion, which Noguchi has named luetin, is an emulsion or extract of cultivated pure *Spirochaetae pallida* which have been killed by heat and then carbolized with one half of one per cent. phenol. The control emulsion consists of the uninoculated culture media, prepared in the same way as the luetin media. The technique is simple; under aseptic precautions a drop of the control emulsion is injected into the skin of the inner side of one arm or forearm; a drop of the luetin emulsion at a corresponding place in the skin of the other arm. Little or no reaction takes place in nonluetetic cases, but when the person is syphilitic a series of changes takes place. In from six to twenty-four hours, as a rule, though perhaps not until after eight days, a distinct papule appears surrounded by a bluish red halo. As the papule grows larger the areola fades away. The papule may be circular or elliptical, is from five to twenty millimetres in diameter, and develops in the majority of cases a central area of suppuration, which ruptures a few days later. As the discharge of the seropurulent fluid occurs the contiguous epidermis becomes denuded. Epidermatization now begins and the affected skin becomes hypertrophic. This hypertrophy persists in cases in which the reaction was marked for at least five months. Smears and cultures made from the pus were found to be negative bacteriologically. Microscopical examination of sections of the hypertrophied area

showed round cell infiltration. As a rule, there is no reaction at the site of the control inoculation in syphilitic persons, but in a small number of cases changes take place that resemble the positive reaction, except that the skin becomes simply discolored instead of hypertrophic. This pseudo-reaction is usually exhibited by persons suffering from tertiary syphilis, and it is thought the peculiar pathological condition of the skin in which there is an increased susceptibility to trauma is present in these cases. Usually there is no constitutional reaction, but in two cases there was malaise on the day following the inoculation, slight elevation of the temperature, and mild gastrointestinal disturbances. Cohen has tried the test in sixty cases. In these the cutaneous reaction corresponded with both clinical evidence and Wassermann test in twenty-eight, with the clinical evidence alone in nine, with the Wassermann test alone in nine, and did not correspond with either the clinical evidence or the Wassermann test in fourteen.—(*Annals of Ophthalmology*).

THE NAUHEIM TREATMENT OF HEART DISEASE; ESSENTIALS, INDICATIONS, AND CONTRAINDICATIONS.—By Hubert Schoonmaker, M. D.—The essentials of the Nauheim treatment of heart disease, as given in our home sanatoria and hospitals to-day, are, first, a course of tub baths in which the temperature, duration, and strength are definitely graded; second, passive or active exercises; third, massage; fourth, rest; fifth, diet.

Let us first consider the most important of these factors, *rest*. The heart that should be most benefited by the Nauheim treatment is the heart that needs rest. Continued rest in bed often saves from ten to fifteen heart systoles a minute, six hundred to nine hundred an hour; an expenditure of force which can ill be afforded by a decompensated heart. Whether rest should be absolute or partial depends largely upon the degree of decompensation and the amount of peripheral resistance that is organic. By organic peripheral resistance, I mean any fixed condition that obstructs the blood current in its normal flow, the most common being contracted kidneys and stiff arteries. The restoration to compensation of a heart dilated from overstrain in one with normal kidneys and resilient arteries is quite a different problem than it is in one with a fixed resistance in the kidneys, or arteries, or both. In any case in which the heart needs rest, we shall all agree that continued rest in bed is indicated, but it is surprising how often we fail just here. This is especially true of chronic kidney patients with secondary cardiac dilatation. They come to us with stasis in the lower limbs and a history of shortness of breath, especially at night, and loss of sleep. Rest in bed is surely indicated, but it is useless to tell a patient to stay in bed when he is suffering from air hunger and knows by experience that he is most comfortable in the sitting position. We should first seek to remove some of the resistance in the tract of the blood current and thus relieve to some appreciable degree the embarrassment in the chest. Digitalis or its derivatives in full doses, if the patient is not already taking them, may do this by stimulating the heart and kidneys to greater action, but it is like making a tired horse draw a load up a hill by using the whip. The better way is to put the patient on a starvation diet for two or three days; for example, allow six ounces of skimmed milk every three hours, clear out the bowels freely,

and give enough of sedatives in small and repeated doses to produce drowsiness. As soon as the edema begins to subside and respiration becomes easier, digitalis in full doses should be given, ten to fifteen minims of a reliable tincture every four hours. When stasis is relieved, the drug should be discontinued or the dose reduced to about one half. I comment upon the use of digitalis in this connection to emphasize the fact that in acute conditions it is seldom given in large enough doses.

There is another way of resting the heart besides relaxation of the body. It might be called the augmentation of a vicarious force. I refer to the induction of increased activity on the part of the vascular system. I am afraid we often forget the very large part that the blood vessels play, independently of the heart, in maintaining the circulation. It is upon this principle that the Nauheim treatment is based. The bath acts in particular upon the cutaneous circulation, and massage and exercise improve the deeper or muscle circulation. An improved cutaneous and muscle circulation means lessened peripheral resistance. Lessened peripheral resistance makes easier the restoration of myocardial tone. If these forces are made active while the heart is at the same time resting, because of bodily relaxation, surely ideal results should be obtained.

The essential of the *bath* in the Nauheim treatment is a graduated series of tub baths covering a period of four to six weeks, in which the temperature beginning at 96 degrees or 94 degrees F. is reduced two degrees each series (every third or fourth bath); the time beginning at six or eight minutes, is increased two minutes each series and the saline and gas ingredients are gradually increased in strength. The gas, carbon dioxide, together with the salts, sodium chloride and calcium chloride, sufficiently stimulate the cutaneous nerves and the skin itself to cause a pronounced redness of the skin, and this in a bath lukewarm to cool. This improvement to the cutaneous circulation, without unpleasant or harmful reaction, is what is sought. We know of no other method as effective.

*Passive or resistance exercises* improve the tone of the vessels within the voluntary muscles, without increasing, to any damaging degree, the heart's frequency. Active exercise is equally effective in cases in which myocardial reserve warrants its employment, but this should seldom be prescribed until compensation is restored. It is the essential part of the "after treatment." *Massage* not only improves muscle and skin circulation, but retards muscle waste while the patient is inactive.

The remaining essential in the Nauheim treatment, *diet*, deserves more consideration than we are wont to give it. A weak heart, especially one responsible for venous stasis, presupposes a weak stomach. Indigestion with accompanying flatulence, distention of stomach and bowels, causes pressure upon the diaphragm, thus embarrassing heart and respiration. In prescribing a diet, the likes and dislikes of the individual should be considered. Diet lists, except for the basic principles which they suggest are a delusion and a snare. Food that requires mastication is to be preferred to soft or liquid foods, because it is less liable to produce flatulence. The diet should be fairly well balanced as to proteids, carbohydrates and fats. The stomach should never be filled. Light meals, sometimes very light, for instance, a cup of milk and a piece of zwieback, from five to seven times in twenty-four hours, according to amount given, serve the



best purpose. There are times, especially when there is pronounced edema, when it is well to limit the amount of food for two or three days to a pint of milk in twenty-four hours. It is not safe, however, to continue the starvation diet many days. Theoretically, a weak heart needs more nourishment than a strong one. Thus, to give enough nourishment and at the same time avoid all digestive disturbance, requires the combined judgment of a physician whose common sense has not been submerged by dietetic hobbies and of an intelligent housewife.

I said at the outset that the heart most benefited by the Nauheim treatment is the heart that needs rest. As a working principle, this is true; but it does not apply to all cases. In considering indications and contraindications, we shall have in mind the bath only, because the other essentials, passive or active exercises, massage, rest, and diet, are indicated in all cases.

The Nauheim bath to be effective must cause capillary dilatation without constitutional reaction that tends to physical depression. Slight depression can be safely ignored so long as the myocardial tone is maintained. Effective capillary dilatation can be had only in one with arteries and capillaries that possess sufficient resiliency to permit of their being flooded. Therefore, the bath is contraindicated in advanced general arteriosclerosis. These patients do much better under a more active treatment if the myocardial reserve will warrant it. For example, incandescent sweating baths, autocondensation, massage, and exercise.

Capillary dilation cannot be effectively secured if the *vis a tergo*—the heart force—is badly crippled. Therefore, the bath is contraindicated in cases of acute dilatation or of lost compensation until compensation is partly restored.

We believe that there is only one valvular lesion *per se*, in which the bath is contraindicated, and that chiefly in cases of congenital origin, or in those in which the lesion becomes a factor in the heart's development; I refer to mitral stenosis. Obstruction at the mitral orifice prevents a free flow of blood from the left auricle into the ventricle; the left ventricle, receiving less blood than the normal, fails in its full development, on the principle that a muscle grows only as work is required of it, or having been normal before the accident of stenosis, the ventricle becomes smaller and the muscle weaker for the same reason.

In what has gone before we have anticipated the indications for this treatment in heart diseases. To summarize, it is indicated in any valvular disease except mitral stenosis, providing the functions of tonicity and contractility of both myocardium and arteries are tangible. That is, in cases in which myocardial compensation is not wholly lost, and arteries and capillaries are not stiffened or degenerated beyond the power to respond to external stimulation. It is indicated in mitral stenosis if the heart at its best, under the embarrassment of the stenosis, is able to maintain a fair cutaneous and pulmonary circulation. It is indicated in myocarditis without valvular lesion, under the same conditions as in valvular disease. The functions of tonicity and contractility must be tangible forces. It is indicated in angina pectoris if the essentials already stated are present. In a word, it is indicated in any case in which the cutaneous vessels are amenable to at least a fair degree of dilatation and at the same

time the heart possesses sufficient reserve to adjust itself to such change in the blood current.—(*New York Medical Journal*).

**SEXUAL NEURASTHENIA AND THE PROSTATE.**—For the purposes of this brief article sexual neurasthenia implies ordinary neurasthenia with a sexual element, either psychic or physical in character. Organic sexual disturbance can hardly exist without a strong incidental psychic element. A purely psychic sexual element in so-called sexual neurasthenia is rare. There is almost always some functional derangement of the sexual apparatus behind which lies a varying degree of organic disorder.

My experience leads me to the conclusion that neurasthenia in the male is associated with prostate hyperemia and hyperesthesia of the prostatic urethra more often than with any other condition.

Knowing the abundant sensory and sympathetic nerve supply of the prostate and its intimate relation to the sympathetic system in general, one should not be surprised at the frequency with which nervous symptoms develop in patients suffering from prostatic disease. Add to the purely organic factors the profound psychic impression made upon the patient by the knowledge of sexual disability and we have a very satisfactory explanation of the frequency of "sexual neurasthenia."

Disturbed digestion, irregular bowel action, headache, depression, lassitude, melancholy and brooding, hypochondriasis and introspection, unstable emotions, and "hysteria"—for there is a condition in the male analogous to hysteria, which we logically might call "prostateria"—are among the results of a sensitive, congested prostate and deep urethra.

The management of sexual neurasthenia, while largely directed to the relief of local conditions, requires even more care and judgment than that of cases of neurasthenia in which there is no sexual element. Regulation of sleep, diet, and work is always in order. Hydrotherapy, general massage, and static electricity all have their uses, in conjunction with prostatic massage, instillations of silver, and, in infected cases, irrigations. Urethral dilations should supplement the other local treatment.

We occasionally meet with cases in which, while the local conditions improve and the neurasthenia is more or less benefited, the patient remains unfit for the active duties of life and becomes a confirmed hypochondriac. For cases such as these complete change of scene and climate is required. A sea voyage sometimes accomplishes wonders.

Sexual neurasthenia associated with real or imaginary spermatorrhea, obstinate prostatorrhea, or seminal emissions occurring frequently and resistant to treatment is sometimes very difficult of management. In such cases I have frequently obtained excellent results from temporary resection of the vasa deferentia. Aside from the moral effect, which is profound, the relative rest secured for the sexual apparatus and the lessened activity of the circulation of the prostate are extremely beneficial.

Cases of sexual neurasthenia with or without prostatic derangement associated with impotency are the most trying of all. If unrelieved, these cases go from one doctor to another and finally land in the arms of the quacks. Many of them are purely psychic at the beginning, but a few recurrences of their inability to copulate puts a large proportion of them

into the permanent class. In such cases the nomenclature "psychic" is not comforting to the patient, and if one stops to think is somewhat absurd. One of my patients rather rudely brought me to a realization of the profession's lack of humor. When I told him that his impotency was purely psychic, he replied: "Psychic h—l! Why, I can't get an erection."

As potency really consists of ability to get and sustain an erection, my patient's point was well taken. I would remark, in passing, that our nomenclature has driven a host of patients to the quacks. The cause of impotency may be psychic, but the lack of erective power *per se* is a purely mechanical proposition.

In many cases of impotency the failure of erective power is due to plainly evident general or local organic conditions. Once the accident of failure of erection has occurred, however, the patient's memory of the first failure is sufficient to cause another and another, until failure is the rule of his sexual life. Here even the removal of the original organic condition is likely to fail to cure.

Morbid prostatic conditions, involving especially the *veru montanum*, often underlie impotence. In such cases massage, silver instillations, or endoscopic applications of silver to the *veru montanum* often do excellent work. Not infrequently, however, all these measures fail completely. Unless the impotency is relieved, cure of the neurasthenia is impossible, hence any measure that holds out hope of relief should be adopted. It has been my experience that a very respectable proportion of cases of sexual neurasthenia associated with impotency are remediable by resection of the *vena dorsalis penis*. As to how far the psychic effect of the operation explains its benefits I am unable to say, but as the local mechanical effects are obvious and constitute the only means of psychically impressing the patient I will not quarrel with terms.—By G. Frank Lydston, M. D., (*Medical Record*).

EPITHELIOMA OF LID CURED BY RADIUM.—The patient, whose age was 54, gave a history of a small growth existing on the lower lid since twelve years previously. This had remained stationary in size for ten years, and had then grown rapidly, following repeated cauterizations with nitrate of silver. A large tumor was dependent from the lower lid and also of the nose. There was almost continuous hemorrhage and the patient's general condition was deplorable. The preauricular and submaxillary glands were enlarged. After a microscopic diagnosis of pavement epithelioma had been made, applications of radium (nine centigrams of the bromide) were instituted. These were almost daily and lasted for from fifteen to twenty-two hours each. The eye was protected with lead. Treatment was suspended several times on account of marked local reaction and fever.

In all, the treatment was used 228 hours. The eye lashes fell out, but grew again. The lens subsequently became cataractous. Cure of the tumor was, however, complete, with but little scar; and after nine months the general health was good, and there was no sign of recurrence. *Dr. Jose Garcia Del Mazo. (Archine de Aftalmologia).*

WILLIAM SPENCER, M. D.



**MEDICAL AND SURGICAL TREATMENT OF TRACHOMA.**—The author gives the following combined methods as his method of choice after an experience with 15,000 cases. With unimportant variations it is the method used amongst the oculists in Egypt. The upper lid is turned and seized between thumb and index finger, between which it is squeezed as hard as possible. The object of this is to bring out all the follicles that are hiding in the tarsus which is completely relaxed by this procedure. The upper lid is then given another turn so as to bring into view the fornix, and all follicles, granulations or papillary hypertrophies are carefully scarified. The same is repeated on the lower lid. Every trachomatous point is then gone over with a sharp curette until the characteristic scraping of the tarsus is felt, especial attention being paid to the fornices. After well irrigating the sac yellow oxide ointment is applied, and a moist bandage used for two hours. After that the eyes are washed every two hours.

On the following six to eight days the lids are touched with a 2 per cent. solution of silver nitrate until entire cessation of the secretion. Then he changes to 1 to 2 per cent. glycerite of copper sulphate. Thus in 15 to 20 days, sometimes in 10, complete cicatrization is attained, thus shortening the usual time of treatment greatly. In 8 to 10 per cent. of the cases there occurred relapses or rather reinfections, in these cases the same method was again successfully used.—Dr. Alexandria Jacovides, *La Clinique Ophthalmol.*

WILLIAM SPENCER, M. D.

**CATARRH FROM ELECTRIC DISCHARGE.**—Two men on mules, and another on foot, received the shock of a sudden electric discharge as they were passing a pole which supported an electric cable. The first two, with their mules, fell to the ground unconscious. On coming to, vision was at first almost absent, but gradually returned. After this, however, the vision of one of them gradually got worse and at the end of twenty-five days scarcely amounted to perception of light and dark.

The second man experienced less disturbance of vision. Three months later, at examination, the first one showed complete cataract in the left eye; the right eye had some retinal disturbances, with vision 5-10. The second man had a stellar cataract in the left eye, with which his vision saw fingers at 0.75 meter; and in the right a small anterior palan cataract had reduced vision to 5-35. Operation on the worse eye of the first patient resulted in vision of 5-15 with lens.—Dr. G. Leon Ortin, *Archives de Optalmologia.*

WILLIAM SPENCER, M. D.

**DECAPSULATION OF THE KIDNEYS IN ECLAMPSIA.**—Iljin (Russia) has made experiments on animals in order to clear up some of the contradictory results observed from this operation. He found that only after increasing the blood pressure by means of normal saline solutions does the secretion of urine become increased from the decapsulated kidney, otherwise the urine may even be diminished. From other experiments also he concludes that decapsulation is only followed by favorable results in eclampsia where there are anuria and high blood pressure.—*Abs. Zentralbl. f. Gyn.*, 1911, 1174.

THEODORE J. GRAMM, M. D.

FINGER INFECTION IN SURGEONS.—In the course of a discussion, Oberndorfer mentioned that torpid ulcerations of the finger are well known to pathologists. It has been shown that they are often tubercular. In the beginning a small, itching vesicle appears. In this stage, according to Oberndorfer's experience during a number of years, the further progress of the disease may be with certainty prevented, if the top of the vesicle be removed with a scissors, the small drop of thin pus expressed and the finger tied up with 96 per cent. alcohol under an impervious bandage, allowed to remain for 24 hours. After this time the skin is of course dried, and the upper epidermal layer will be loosened in the course of a few days, but the lesion is healed. He warmly recommends the procedure.—*Monatssch. f. G. u. G. Vol. 33*, 659.

THEODORE J. GRAMM, M. D.

TUBERCULIN REACTION IN GYNECOLOGY.—Schlimpert made the test in 40 cases of adnexal, bladder and kidney diseases, in which the clinical diagnosis and the reaction diagnosis were confirmed by histological examination of the specimen obtained by operation, or bacterial examination of the urine. As opposed to the results of Birnbaum who had 94 per cent. positive reactions, Schlimpert saw in 72 cases of adnexal disease examined with old tuberculin, 64 per cent. positive and 31 per cent. negative results; and in 19 cases of urogenital and peritoneal tuberculosis, 47 per cent. positive, and 53 per cent. negative. He concludes therefore that the subcutaneous reaction with old tuberculin of Koch, as well as the Moro and Pirquet reactions, have no diagnostic value in gynecology.—*Abstr. Zentralbl. f. Gyn.*, 1911, 1044.

THEODORE J. GRAMM, M. D.

SUCCESSIVE TUBAL PREGNANCIES.—Rabinowitz reaches some interesting conclusions which are as follows: pathological and clinical studies furnish sufficient data to justify the deduction that gonorrhoeal salpingitis is the predominant cause of tubal pregnancy, and that the lesion most likely responsible is the destruction of the ciliated epithelium. The ascending infection effects the tubes, in the majority of cases successively. It is therefore not unusual for the tube that is left *in situ*, on account of its apparent normal condition, to undergo further pathological processes sufficient to furnish a predisposing factor for a recurrent tubal gestation. Plastic surgery on the unimpregnated tube, such as liberating it from chronic adhesions or the opening of its fimbriated end by dilating or resection, is a meddlesome procedure, because it exposes the patient to the risk of subsequent ectopic gestation. When operating for tubal pregnancy, the unimpregnated tube should be carefully examined, and if in addition to a gonorrhoeal history we find evidences of a recent or of a remote pelvic peritonitis, salpingectomy should invariably be done thereby preventing recurrent ectopic gestation.—*Amer. Jr. Obs. Vol. 64*, 238.

THEODORE J. GRAMM, M. D.

BACTERIOLOGY OF IODINE IN SKIN STERILIZATION.—Bovee (Washington) has reported some bacteriological investigations of the use of iodine solutions in skin sterilization for surgical purposes, and a resume of his results shows that weak solutions of iodine even to 5 per cent. of the of-

ficinal tincture, thoroughly sterilize the surface of the skin after two to fifteen minutes. While the inhibitive action of absolute alcohol is quite potent, this property is greatly enhanced by the addition of iodine to an equivalent of 5 per cent. of the U. S. P. tincture. Pubic hair placed in iodine dilutions of various strengths up to 4 per cent. of the officinal tincture all showed growths, while using 50 per cent. dilutions under the same conditions practically always prevented growths. Control scrapings of skin taken from the abdomen above the umbilicus over periods of time varying from 2 minutes to two hours when 40 per cent. dilutions were used always showed negative results as to colonies. Cultures from hair and skin that had been subjected to 50 per cent. dilutions never produced growths. Tincture of iodine diluted with equal amount of absolute alcohol may be considered reliable as a local application in preparation of skin or mucosa in any part of the body. Dilutions of less strength are unreliable if hair or large hair follicles are in the field of operation. The 50 per cent. dilution of tincture of iodine, if not carelessly applied, is not likely to injure the skin.—*Amer. Jr. Obs. Vol. 64, 91.*

THEODORE J. GRAMM, M. D.

PLACENTA PRAEVIA.—Cragin has described the treatment used at the Sloan Maternity to consist in (1) Dilation of the cervix and control of the hemorrhage with the largest Voorhees bag which can be introduced, i. e. No. 3 or 4; (2) After the largest bag has passed the cervix and good dilatation is obtained, either a version is done and the child delivered by the breech, or, if the placenta praevia is lateral or even marginal, with slight hemorrhage and the vertex presents, the membranes are ruptured and the head allowed to come down and exert pressure upon the lower uterine segment and edge of the placenta, the delivery being expedited by the forceps if necessary. From the above description it is seen that this use of the elastic bag is extraovular and that the membranes are kept intact until the bag passes the cervix and good dilatation is obtained. This method is preferred by the writer to the intraovular use of the bag chiefly in the interest of the child, but with little if any detriment to the interests of the mother.

If the membranes are ruptured and the dilating bag placed within the amniotic sac, the version which follows has to be performed in a uterus largely emptied of fluid and with greater danger to the child and greater danger of rupture of the uterus—an accident unfortunately not uncommon in placenta praevia. Experience also proves that the presence of the dilating bag beneath the edge of the placenta in an incomplete placenta praevia usually checks the hemorrhage without dissecting the placenta to any great extent from the uterine wall, and in the complete variety it has seemed to cause less natural blood loss when used beneath the placenta than when the placenta has been bored through and the bag placed above the placenta in the amniotic sac. The use of the elastic bag both to dilate the cervix and to control hemorrhage, may well summarize the method of treatment preliminary to any method of delivery. This applies to any case needing any treatment save that of a normal delivery.—*Amer. Jr. Obs. Vol. 64, 57.*

THEODORE J. GRAMM, M. D.



## Monthly Retrospect

### OF HOMOEOPATHIC MATERIA MEDICA AND THERAPEUTICS

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Miami, Florida.

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REMEDIES FOR COUGHS. BELLADONNA.—A dry cough, spasmodic cough with dryness, rawness and scraping in the larynx. Every now and then you get attacks of suffocation with the paroxysms of cough. The only time you find anything like moisture with the belladonna cough is when a person suffering from chronic catarrh contracts a cold. Then the mucus is seen and felt in shreds.

SPONGIA.—A dry suffocating cough with soreness and burning in the chest. The patient is very hoarse. There is a sense of constriction of the larynx which makes the respiration difficult. The difficult respiration often accompanies the dry metallic cough and there is a feeling as if the breath passed through some porous substance. *The dry cough and constriction are both relieved by eating and drinking.*

RUMEX.—An incessant, dry, spasmodic cough, worse by breathing cold air, by lying down, at night. The irritation causing the cough is from mucus which produces a tickling behind the sternum. The time of day is from 10:00 to 12:00 p. m. *There is relief from covering the head and breathing under the bed clothes.*

STICTA.—A nervous, dry, incessant, hacking cough, sometimes in spasms like whooping cough. Usually a remedy for nervous, reflex cough and whooping cough, but occasionally the incessant irritating cough of measles. Although nothing seems to ameliorate the cough of sticta, *it is decidedly worse towards evening, or when the patient is tired.*

CAUSTICUM.—A hollow, dry, hoarse cough with soreness and rawness down from the trachea. The causticum cough is the opposite of rumex in that it is worse when covered up warm in bed. *It is relieved by sips of cold water.* The feeling as if there were mucus in the larynx which the patient cannot get under and raise is very marked in causticum. With the cough the patient involuntarily voids urine.

BRYONIA.—A dry, hacking cough from irritation in the upper part of the trachea. Every time the patient coughs there is a feeling as if the head and chest would *burst*. The bryonia cough is sometimes called a "stomach cough," because it is aggravated by eating and drinking. With the cough there is a sharp sticking pain beneath the sternum, in fact, all through the chest. After a few hours the cough may become just a little moist and you have a small amount of mucus streaked with blood, expectorated. *The marked aggravation of this cough is from coming from a cold into a warm room.*

**PHOSPHORUS.**—A dry, rough, hoarse cough, with tightness or oppression of the chest and spurring of urine during the cough. Phosphorus has two marked aggravations, 1st, *talking, laughing, and singing*; 2d, *going from warm into cold air*. There is a good deal of burning in the larynx also beneath the sternum. Notwithstanding the dryness of the cough and burning you may have mucus, frothy, bloody, purulent mucous expectoration. With the cough of bronchitis and pneumonia the phosphorus patient cannot lie on the left side without attacks of suffocation.

**IPECACUANHA.**—A constant, rough, shaking, ineffectual cough. Ineffectual in the sense that mucus of which there is a large amount in the bronchial tree cannot be dislodged by coughing. *The cough causes much nausea, "gagging" and sometimes vomiting.* With the different conditions in which you find ipecacuanha cough you have a *wheezing, whistling, in the chest.*

**HEPAR SULPH.**—Hepar seems to have a dual cough as well as a dual action for suppuration. It is useful for a dry and for a moist cough. The dry cough is usually worse in the evening, the moist loose in the morning. *The keynote to either variety is "cold" and "cold air."* If a draft of air strikes the patient or if any part of the body becomes cold the mucus of the loose cough seems to tighten and the paroxysm of the cough becomes more violent and prolonged. *"Cold" and "cold air" also aggravate the dry cough.* The hepar patient always sweats when coughing.

**TARTAR EMETIC.**—Coughing and gasping in alternation, a loose cough with little expectoration, much rattling of mucus in trachea. The cough compels the patient to sit up in order to breathe. The face is pale, cool, and moist. The pulse is rapid, weak and trembling. Great rattling of mucus in the chest is the keynote to the remedy.

With the belladonna, spongia, sticta, and causticum, I habitually use cold water compresses as follows: Dip a piece of linen in water at temperature of 60 or 65 and wrap around the neck. Over this put a flannel cloth to protect the clothing. Change as often as it becomes dry.—*Pacific Coast Journal of Homeopathy.*

**REPORT OF A CASE OF BELLADONNA POISONING IN A CHILD SEVEN YEARS OF AGE.**—(Robert E. Coughlin, M. D.). Because of the rare occurrence of this form of poisoning, as the writer believes, the following case is reported. None of the text-books go into the particular instances of poisoning by belladonna. Indeed the action of belladonna from a physiological dose standpoint receives very little space, but the action of atropin, which it is said to resemble, is generally put down as being the cause of a long line of symptoms, notably, dryness of throat, dryness of mouth, some disorder of vision, redness of face, dilated pupils, possibly diplopia, rapid heart action, rash of neck and face which may spread all over the body, lightness of head, giddiness and confusion of thought, staggering gait and restlessness. Drowsiness is a characteristic symptom. Sometimes the delirium is wild, but as a rule active talkative wakeful delirium is present, where the patient appears to be living in a world of his own, engrossed by the spectres and visions which throng him, completely oblivious to surrounding realities.

It goes without saying that when we have a drug with such potency we should be very careful in its administration, especially in children, therefore belladonna and other poisonous drugs should not be administered by the drop method for the reason that the dose is too inaccurate and variable in consequence.

CASE. F. S., aged seven years. Family history: Father died of tuberculosis at the age of twenty-five years. Mother alive and well, though there was a tuberculous taint in her family. Her mother died at the age of fifty-four years from acute pneumonia, which complicated a chronic tuberculous condition. Her father died of tuberculosis at the age of forty-two years.

The child, F. S., is a healthy, robust appearing boy, but has always had the wetting of the bed habit. For this condition the tincture of belladonna was prescribed by a physician, who was a friend of the family, in ten drop doses three times a day. This treatment was continued for about one week's time when patient's mother noticed that he was becoming drowsy. She continued with the medicine, however, till the next morning when the boy arose from his bed much earlier than usual, complaining of a sick stomach. There was no vomiting, however. He said he arose early because some one had called him, although this was not so. Immediately upon entering the kitchen he proceeded to remove all bottles from the shelf. Next he said, "O look at the mice." After this he said he saw rabbits, goats, and baskets of candy eggs. Among all these things was a fountain pen which he repeatedly tried to pick up from the floor. On looking out of the window he saw the fences all decorated with red, white, and blue for the parade which he was positive was to occur on that day, although in reality no parade was to occur. Apparently no one could make him believe otherwise. Next he saw six soldiers climbing up a tree without holding on to the branches. At all this he laughed with the greatest glee. Next he saw stars on the parlor carpet. When his relative came into the room he immediately proceeded to pick up one of the stars for her. He ate his breakfast as usual, but persisted in asserting that the table was filled with crullers, which of course was not so as there were no crullers in the house anywhere on this particular occasion. He also thought he saw a watch surrounded by pieces of fancy paper all over the floor. Next he saw a pool of water over which he jumped and said: "There, I'm over." Later he compelled his mother whom he believed to be his teacher, to take him out to see the parade, which he to all intents and purposes enjoyed for fully an hour's time. His mother becoming tired of standing on the street so long, had to almost drag him away from the curbstone. He demurred, however, to such an extent that she had to go back with him again till he believed the parade was over, after which he willingly returned with her. On the way she was compelled by his entreaties to buy a flag for him. This he carried and waved all the way home, though his flag was the only one to be seen on the streets that day. When they arrived home he immediately began to entertain his friends who were present with an imaginary cigar, which he thought he was able to make appear and disappear at will. During all this time he leaned forward in walking and seemed to be walking on his toes in a stealthy sort of a manner. His pupils were very much dilated and he



was apparently looking into space. His face was very red, while in his normal condition he is what might be called a pale child.

The treatment was a good dose of castor oil. Full recovery occurred in twelve hours' time, when he was put to bed, and awoke the next morning perfectly well again, attending school on the following day, as usual.

For two nights previous to the poisoning there was no enuresis, nor did he wet the bed on the following night, but on the second night succeeding the poisoning the incontinence was resumed, and has been continued ever since to a far greater extent than at any time before, presumably making up for lost time.—(*New York Medical Journal*).

SCILLA.—By Horace P. Holmes, M. D., Sheridan, Wyo.—*Scilla maritima*, or Squills is the common squills of household and old school practice. It is a sea onion found about the Mediterranean. There are two varieties, the white and the red, the latter of which is used in the preparation of our homœopathic remedy. We use it in the form of a tincture.

*Scilla* was proved by Hahnemann and his associates and but little has been added to its literature by either Allen or Hering in their complete works. The latter author starts his article in Guiding Symptoms with: "Great anxiety of mind, with fear of death," so identical with *Aconite* and *Arsenicum*. This symptom, like so many others in our materia medica, may be misleading, as both anxiety and the fear of death may not be present at the same time. As anxiety was a prominent symptom, and fear of death was observed, Stapf put the two together. We may meet with anxiety under this remedy but not necessarily fear of death. The patient is irritable, angry about trifles as in *Chamomilla*, with aversion to mental or physical labor, which might make sea onions a good diet for Coxy's army.

The headache of *Scilla* reminds us of *Bryonia*. There is headache in the morning on waking, pulsation on raising the head. The child rubs its face and eyes a great deal, which is similar to *Cina*. *Cina* rubs and picks at the nose, while in *Scilla* it is the face and eyes, as if to relieve the itching.

In the eyes there is a sensation as if swimming in cold water, or sensation of cold water in the eyes when in cold wind. Remedies having a somewhat similar symptom are: *Lachesis* has "cold tears." "Cold feeling in eyes" is found under *Berberis* and *Medorrhinum* while *Thuja* has "sensation as if cold air was blowing out through the eyes." "Eyes seem cold," *Euphrasia*. "Coldness in eyes," *Alumina*, *Conium*, *Lycopodium* and *Platina*. The upper eyelids may be swollen in *Scilla* as in *Kali carb*. *Elaps* has the symptom, "Bloated around the eyes in the morning."

*Scilla* has an exciting action on the mucous membranes as shown by the symptoms of the whole respiratory tract and the urinary system. There is sneezing, coughing and watery eyes so characteristic of *Allium cepa*, *Euphrasia* and *Pulsatilla*, and in measles. There is an acrid, fluent coryza, worse in the morning. Hering characterizes it as "A regular snizzle," if anyone knows what that means. "Snizzle" is a new word to me, and is probably a misprint for snuffle. This symptom reminds us of one of the other onions, *Allium cepa*. The nostrils are painful as if sore,

with violent coryza, as in *Allium cepa*, *Arsenicum*, *Arsenicum iodatus*, *Arum*, *Mercurius cor.*, etc.

Food tastes bitter, especially bread. *Asarum* has "bread tastes bitter."

There is great irritation, burning and dryness in the throat, like *Arsenicum* and *Capsicum*. There is an irritation to cough in throat, in upper part of trachea. There is nausea during morning cough, and nausea in back part of throat. This is probably sympathetic, caused by the irritation and fullness in throat.

Among the stomach symptoms we have "pressure like a stone," characteristic of *Arsenicum*, *Calcarea carb.*, *Graphites*, *Nux vomica* and *Pulsatilla*.

Stools involuntary when coughing, sneezing or passing urine. *Phosphorus* has involuntary stool when coughing, and this symptom I have repeatedly verified. *Sulphur* has involuntary stool when sneezing. Involuntary stool while urinating is covered by *Ailanthus*, *Aloes*, *Muriatic acid*, *Scilla*, *Sulphur* and *Veratrum alb.* *Scilla* is the only remedy having all three conditions causing involuntary stools. This symptom, together with the throat symptoms, shows *Scilla's* relaxing effect on the orifices of the body.

The urinary symptoms point to the use of this remedy in certain dropical affections, cystitis, enuresis and diabetes. There is sanguinolent urine with a red deposit, as in *Terebinth*, with tenesmus after micturition, as in *Cantharis*. The frequent calls to urinate at night, passing large quantities of pale urine, recalls *Phosphoric acid*. There is violent urging to urinate with large quantities of pale urine, which suggests the remedy for diabetes.

In its action on the kidneys, Hahnemann brings forth an illustration of the primary and secondary action of *Scilla* which applies to many other remedies—notable *Apocynum can.*—and which should be borne in mind by the superficial homœopath. *Scilla* in large doses causes a profuse secretion of urine and was used by the Egyptians in dropsy and with great rejoicing when this large discharge of urine was produced. But the secondary action, which is a scanty secretion, soon follows, and the disease is really made worse by the remedy. We homœopaths, as well as all other physicians, should realize that a prompt, active diuretic is a bad remedy to give in dropsy due to insufficient urination, for, while the primary action seems to produce the desired result and to indicate intelligent practice, the secondary action, which is opposite and sure to follow, leaves our patient worse than before. This recalls Hahnemann's early observation, while he was an old school physician, that many of his patients would have done better had he left them.

It is mainly in the respiratory tract that we find the useful sphere of *Scilla*. It covers bronchitis, pneumonia, whooping cough and asthma. There is wheezing, rattling and dyspnoea. The patient must sit up. There is shortness of breath on exertion and ascending, as in *Arsenicum* and *Calcarea carb.* There is dyspnoea so great that the patient cannot drink for want of breath. *Kali nitrate* has the same symptom. The child grasps the cup greedily, but can only drink a sip at a time for want of breath.

The cough is terrific, and its fierceness, persistency and staying qualities are equalled by few remedies. We find the peculiar symptom: "Spurt-

ing of urine when coughing." This is found under but few remedies, notably *Alumina*, *Causticum*, *Conium*, *Natrum muriaticum*, *Pulsatilla* and *Veratrum album*. The cough is dry at night and loose in the morning. It is more fatiguing when loose than dry, but is tedious at any time. The cough is worse from cold drinks, from exertion and from change from warm to cold air. *Silicea* has cough worse from cold drinks, while cough worse from change from warm to cold air calls for principally *Carbo veg.*, *Phosphorus*, *Rumex*, *Scilla* and *Veratrum album*.

*Scilla* is indicated in the cough of measles and also by the skin symptoms of that disease.

Every fit of coughing winds up with sneezing and involuntary urination. I have several times verified this symptom. The sputum is white or reddish mucus. It may be sweetish and offensive, as in *Calcareo carb.* and *Stannum*. It may be in small round balls, very difficult to expectorate. Drinking cold water brings on the cough. *Lycopodium* has cough aggravated by drinking cold water, *Silicea* cough excited by cold drinks, while *Causticum* has cough relieved by drinking cold water.

The chest and lung symptoms are most familiar to *Bryonia*. There are stitches in the chest, stitches under the last ribs, stitches on inspiration, stitches under scapula, and severe stitches under sternum—so severe as to make it difficult to draw a breath. *Bryonia* and *Kali carb.* are probably the nearest related to *Scilla* in stitches in the chest. There is profuse secretion of tenacious white mucus, expectorated only after severe coughing. Hering gives the indication, once very valuable but now obsolete: "Especially suitable in pneumonia and pleurisy after blood letting."

One must not forget that the arguments regarding the action of *Scilla* in dropsical affections, when given in appreciable doses, apply also to lung and bronchial troubles. Large doses of *Squills* increase the mucous secretion and thereby make expectoration easier. This is the primary action. But the secondary, opposite action follows, and if the trouble is long-lasting, or with a chronic tendency, the mucus becomes tougher and the cough dryer.

There is convulsive twitching in the limbs, both in arms and legs, worse mornings and from motion. There are cold hands and feet and cold foot sweat. Rheumatic pains which are worse during motion. The limb symptoms remind us of *Bryonia* and *Calcareo carb.* "Icy cold hands and feet, with warmth of the rest of the body," is a symptom found in such words only under *Scilla* and *Menyanthes*. Icy cold feet calls principally for *Cedron*, *Elaps.*, *Phosphorus*, *Scilla*, *Silicea* and *Veratrum album*. Sweat only on toes, *Scilla*. Sweat under toes, *Taraxacum*.

In fever there is aversion to being uncovered. When he uncovers during fever he suffers from chilliness and pains, as in *Nux vomica*.

*Scilla* is not only compatible after *Bryonia*, but it is a very close analogue of that remedy. It has its opposite symptom in cough, as *Bryonia* is worse in change from cold to warm air, while *Scilla* is worse in change from warm to cold air. In the furious, exhausting cough we would compare it with *Corallium*, *Cuprum* and *Stannum*.—(*Homoeopathic Recorder*) December, 1911.

THERAPEUTIC POINTERS.—While the reader may never be called upon



to treat a case of beri-beri it may be interesting to know that Dr. J. N. Majumdar, of Calcutta (*Indian Homoeopathic Review*, July) says that "*Rhus tox*, generally is our principal remedy." There are other remedies, of course, that may be called upon according as the symptoms develop.

Dr. S. C. Paul, in *Indian Homoeopathic Review*, July, makes the following peculiar distinction between the homœopathic preparations of *Tuberculinum* and *Bacillinum*, in tuberculosis, derived from his experience as a practitioner, namely, that *Tuberculinum* acts well where the climate is dry and *Bacillinum* where it is wet and in marshy districts.

"Guaiacol pure, full strength, rubbed lightly, not too hard, over a pain will stop it instantly, good in facial neuralgia, uterine contraction in delivery pain reduced to nothing; in delicate skins mix half with vaseline or castor oil. In toothache a small piece of cotton saturated with guaiacol and pressed tight into the tooth gives ease in a few minutes."—*Broadnax in Sept. Wis. Med. Jour.*

In a general discussion of tonsils, adenoids and goitre (*Iowa Hom. Jour.*, Nov.) Dr. Nettie Campbell told of a bad case in a young child which improved under *Tuberculinum* and *Malandrium*, but under "Guenther's goitre tablets" in two months the goitre was gone. She also praised *Baryta carb.* in tonsillar troubles, curing cases in which it had been said that nothing but an operation would avail. Other doctors also praised the action of this remedy, but some maintained that it was a waste of time to do anything but operate. Burnett said that *Bacillinum* once a week should always be considered in tonsil cases.

NOTE UPON THE ACTION AND USE OF DIGITALIS.—Albert E. Hinsdale, A., B., M. D., Bay City, Mich. (*Medical Century*, January, 1912).—*Action of Digitalis*.—Probably more attention and study has been devoted to the physiological effect of digitalis than any other remedy, and its action is not yet fully or correctly known. This latter fact is shown by perusal of literature discussing its action which contains statements contradictory in character. The following is a summary of what the most of the authorities agree upon concerning Digitalis:

(1) Digitalis increases the strength of the heart's action provided two very necessary conditions are present: (a) A healthy cardiac muscle upon which to act and (b) "the rapidity of the heart's action should be greater than that which is normal to the patient in normal health."

(2) Digitalis improves the force of the cardiac contraction and accompanying this action there is a lessening of the number of the heart beats per minute.

(3) Digitalis, largely through the effects of the digitoxin which it contains, increases the force of contraction by direct action upon the myocardium, usually accompanied by diminution in rate as a secondary effect due to its vagus stimulation; thus acting both centrally and peripherally. The heart is slowed and diastole increased.

(4) Digitalis has diuretic properties, the amount of urine excreted depending upon the preparation of the drug used. Digitalis contains at least four active principles, viz., digitonin, digitalein, digitalin and digitoxin. The last three are very similar in action. They all act upon the heart and in a very mild degree cause an increased excretion of urine.

The first one, however, has little or no effect upon the heart, but has the diuretic properties of the other three in a very pronounced degree. Consequently when it is desired to give a preparation of digitalis that acts upon the heart the tincture or fluid extract is used because these preparations contain the "heart elements" of the drug; as the English say, they are the cardiac whips. When it is desired to produce increased urination the infusion should be employed because this preparation contains more of the digitonin.

(5) Arterial pressure is increased in mitral regurgitation. This is accomplished by adapting the arteries to the diminished volume of blood that moves forward. At the same time the heart is "braced up" and its contractions slowed.

(6) "In aortic regurgitation by throwing increased pressure upon the interior of the left ventricle, digitalis adds to the difficult task the heart already has of ejecting a greatly increased quantity of blood from its cavity."

*Some Digitalis "Don'ts."*—(1) Don't prescribe Digitalis the instant "heart disease" is diagnosed. There are good chances that some other remedy will be better suited to the condition. With many physicians the moment "heart" is mentioned down comes the digitalis bottle. This is a nefarious practice and its indiscriminate use in some cases is little short of criminal.

(2) Don't give digitalis in too large doses. It is always better to err on the side of the small than of the large dose. In many cases a dose three or four times a day, or a tablet of the 1x or 2x trituration, will be sufficient.

(3) Never prescribe digitalis in cases of aortic regurgitation. "The inappropriateness of this drug in aortic regurgitation is explained by its diminishing the rapidity of the heart's action, prolonging the diastolic filling of the ventricular cavity and increasing the peripheral pressure which the heart has to struggle against." Seymour Taylor considers the use of digitalis in aortic insufficiency as not only a dangerous drug but an actual poison.

(4) Don't give digitalis in physiological doses when the heart tissue is not normal in character, as in the feeble heart of fevers. This rule is frequently violated. Apparent improvement does sometimes manifest itself, but these are the cases which later on die suddenly—poisoned by the accumulative effect of digitalis. In these conditions either use strychnine in small infrequent doses or else use digitalis upon its homœopathic indications in a potency not lower than the 2x.

*General Remarks.*—If digitalis be given upon its proper physiological indications its use will be the exception rather than the rule. It is a drug which is frequently mis-prescribed and it has been terribly abused. However if given when it is indicated it comprises a most valuable adjunct to the treatment of cardiac affections. Cratægus is a drug which should frequently be given when Digitalis is prescribed. The indications for cratægus are not definite; about the most we can say relative to its indications is that it has answered well in cases where digitalis is contraindicated. It is a good remedy for the careless and routine prescriber to use because if no good follows no harm can result.

Digitalis being contraindicated in fever patients strychnine may be used if a stimulant seems necessary. This is owing to the fact that strychnine acts upon the nervous mechanism of the heart only while digitalis acts directly upon the cardiac muscle.

In some hospitals the infusion of digitalis constitutes the routine treatment for dropsical effusions. There is no objection to the use of the drug in these conditions provided it "works." Many patients are not influenced by digitalis infusion and resort may be had to other methods of treatment. In these cases the eclectic preparation of apocynum works well. Profuse diuresis has been caused by apocynum after failure to get relief from digitalis.

Digitalis is contraindicated in gross physiological doses which produce the ordinary first effects of slowing the pulse and giving to the heart a steadier motion in ordinary febrile cases. Just because the heart is weak and a "whip" is desired digitalis is usually to be ruled out owing to the fact that it acts so energetically upon the myocardium, which is suffering, under such circumstances, with degenerative tendencies. Strychnine is there preferable for reasons already given.

**THERAPEUTICS OF DERMATOLOGY.**—By J. Henry Allen, M. D., Professor Dermatology, Hering Medical College, Chicago, Ill.—Cinnabaris. The symptomatology of the sulphide of mercury is a blending of the mercurial phenomena with the psoric or sulphur proving. These materia medica studies are more difficult to understand than where a remedy is not a compound. To apply them, we must understand the phenomena of a pseudo or mixed miasm. We have many remedies of this order where psora is combined with a syphilitic taint to that degree that we see clearly the symptoms of both diseases. Again, in what is known as the mixed miasms, are the mixed venereal, condylomati, syco-syphilitic eruptions that bleed easily like nitric acid, and are aggravated by heat and at night. They are ameliorated by the open air and at evening.

*Skin Diseases.*—The eruptions are usually moist, foul smelling and of a deep red color. The eyelids are granulated, canthi and lids very red and covered with a yellowish green, purulent secretion. The saliva is increased, even to ptyalism. The taste is metallic. There are sores on the external genitals or mucous outlets, ulcers, warts, condylomati, coxcomb, cauliflower excrescences; round, red, circular points or spots on the corona glandis. Syphilis, sycosis and psora well blended together and all more or less active. There may be eczema about the thighs, in the bend of the elbows or knees, with brownish stains in the surrounding skin. Chronic impetigo, the upper lip has pustules that are moist and red with heavy thick crusts. The skull bones, hair and scalp are very sensitive to the touch. All discharges are copious, thin and of a dirty yellowish-green color and very fetid, similar to asafœtida. Pains in the long bones when the barometer lowers, or worse at night, due to syphilis. The pains are shooting, darting and flash-like; worse from walking. Warts, large or small, covered with a purulent secretion, bleeding easily. Eruptions between the thighs itching worse at night. Pustular eruptions and sycotic excrescences about the mucous outlets or external genitals, prepuce or uvula. Gonorrhœa of long standing, with yellowish-green discharge.



(Thuja, nitric acid, sarsaparilla.) Ulcers very red and granular, covered with a dirty pus, and bleeding easily.

*Rock Rose.* This wonderful little plant is gifted, when potentized with remarkable power as a curative agent. It takes hold of the perverted life forces with vim and energy. Its fort is seen in the scrofulous or strumous subject. All of its provings border on the malignant or semi-malignant. It spends its forces on the glandular system and the skin. Enlarged glands become scirrhus and take on a cancerous nature. It has epithelioma of the lip, nose, tongue and of the skin, caries of the bones, especially the lower jaw (phos.). Discharges from open sores are thin, watery, and the smell very offensive. Scrofulous swelling and suppuration of the cervical glands. We may think of it in goitre, in cancer of the breast, uterus, tongue, lips, nose or face.

*Skin Symptoms.*—Eczema, fissum; skin of hands hard as a piece of leather; thick, dry and fissured; cracks deep, especially is this true of the hands of laborers. It may be useful in hospital gangrene, erysipelas, phagædemic ulcers, poisoned wounds, or bites of animals. Formication is quite a constant symptom; it may be local or general. It has cured lupus of the face with glandular involvement, and tuberculosis of the hip joint. Boils beginning with blisters may require it. Ulcers, surrounded with great induration and swelling of the glands. The gums often become scurbutic and bleed easily. The patient's symptoms are relieved by fresh air or by an open window, like pulsatilla; also after eating.

*Clematis.*—This is another sycotic remedy; purely so. It will often be called for in those forms of gonorrhœa that develop into rheumatism or take on a rheumatic phase. It is indicated in chronic gleet, gonorrhœa of the rectum, with cystitis, sycotic pruritus ani, chronic stricture, orchitis or a stasis of the disease to the testicles. It vies with bryonia or pulsatilla, but the bladder symptoms are more apt to be present in clematis. I have cured the most difficult cases of subacute orchitis with it. Quite often we meet with the sickly, sallow face of one suffering from a suppressed gonorrhœa. Cystitis often follows a suppression or a severe form of coryza, a stoppage of one nostril, while the other is discharging copiously. Burning in the orifice of the urethra, with long, continued contraction and constriction. The urine is shut off suddenly, with stitches in the urethra.

*Skin Symptoms.*—The eruptions are usually vesicular, resembling rhus tox. It seems to come in between rhus tox and rhus radicans, but the itching is better after bathing and better by an application of cool water. In this it is unlike rhus. It is better from moving about, like rhus, but the patient must be in cool air. Rhus is generally relieved by motion. Eczema in growing infants has a vesicular form; the part affected is very red and angry looking. Itching is intense. You will find this form of eczema in children born of very sycotic parents. It is usually confined to the face, but it may appear anywhere over the body. The itching is a painful burning, and is worse by touching or scratching. There are itching vesicles on the face or thighs.

*Dermatitis.*—Parts very red, angry, and intensely itchy. Pustular eruptions here and there through the intense erythema. Prickling like needles or sudden lightning-like stitches. Itching violent, with formication in the

eczemas, especially about the scrotum. The scratching is followed by an intense burning. The chilblains have an intense burning itching. It vies with cantharis in its urinary symptoms, and with rhus in its skin symptoms. The symptoms greatly increase toward the full of the moon; also worse in cold weather and uncovering. Scirrhus of the mamma, worse in cold weather. Skin very red, inflamed and burning. Eruptions of blisters, which burst and form ulcers. Eruptions that dry up during the new moon, and become moist and very much aggravated during full moon.

*Case.*—Child six weeks old. The father had chronic gleet. The child's face was a solid mass of brown crusts, rough and coated over with a dark yellow serum. The discharge excoriated the healthy skin which it passed over. The itching was violent. When the child's hands were tied it rubbed the face back and forth on the bed clothes or pillow. It turned over on its side without any assistance during the night and rubbed its face in the pillow until it was covered with blood. The itching was relieved for a time by washing with cold water. Dark red, fine eruptions came out over the body after a suppression of gonorrhœa. Impetigo after sycotic infection. The serum was thin and straw-colored, like rhus. The eczema of the hands was moist, scaly; the crusts thick and light brown.

*Cobaltum.*—The proving of this remedy by Drs. Hering and Jones and others presents a constant interchange of moods of mind. At first the patient becomes greatly exhilarated, great vivacity, and a rapid flow of ideas, but when reaction takes place he becomes moody, low-spirited, deprecating self. At times he has a superfluous amount of energy and likes to work; then again he has no desire or energy to do anything. There is a dullness, a weakness and aversion to any mental labor whatever. The head feels dull and stupid, and the patient often suffers with a dull frontal headache all the forenoon, or he suffers continually with a sour stomach and a frontal headache. Temporal headache with sour stomach, nux vomica. This headache is worse about 11 a. m. The diarrhœa of this remedy is accompanied with much loud rumbling and colicky pains in the lower bowels. Yet, on the other hand, they may be constipated; stools dry, hard, lumpy and scant.

*Skin.*—Eruptions dry and pimply. Pimples about the nates, containing a lymph, and bleed easily when scratched. Boils about the chin, very small but quite sore. Small, sensitive boils in the hairy scalp or about the margin of the hair.

*Comocladia.*—*Skin Symptoms.*—Eruptions dry and usually papular. Eruption of small, red papules, like scarlet fever, over the whole body, which burn like fire. Eruption of dull, red, hard papules all over the abdomen and anterior surfaces of the body; later on they become dry and scaly. Ulcers deep, with hard edges and a discharge of thick, purulent, greenish yellow matter of fetid odor. Tormenting itching, burning over the whole body, relieved momentarily by rubbing. Itching worse in the palms of the hands, on the scrotum or about the mouth. Itching of the scrotum very severe. Tingling in the skin, which gradually grows more severe. The itching is better by scratching and open air. Itching and tingling also severe in lower extremities. The itching is worse in a warm room and during rest.

# THE HAHNEMANNIAN MONTHLY.

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## HAEMORRHOIDS AND THEIR RADICAL CURE.

BY

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THE subject that I desire to present to this Society has to do with some of the characteristic features and the radical treatment of a surgical lesion that, in point of frequency and amount of suffering involved is in a class by itself, namely, haemorrhoids.

Patients, as a rule, intelligent or otherwise, with symptoms referable to the lower bowel, imagine they have *merely piles* when, upon examination, there may be found any disease from a broken coccyx, to an inoperable cancer of the rectum. This erroneous idea is most unfortunate, inasmuch as piles, innocent in themselves, are not infrequently secondary to a grave disorder higher up, in which event the case is hopeless when the physician is finally consulted because of the loss of valuable time in employing many of the advertised "Sure Pile Cures," "Home Remedies" and "Tips" from friends. The following case will illustrate the point in question:

A female, age thirty-two, consulted me for the purpose of having her "self-diagnosed" piles removed, which she claimed had annoyed her for two years. During that period she had purchased innumerable quack "pile cures" and, in addition, had followed the advice of kind friends to do this, that and the other thing, each suggestion being a sure cure. Not until her



sufferings became unbearable did she consult the writer. Upon examination there was found an enormous infiltrating, nodular growth, carcinomatous in nature, about two inches above the mucocutaneous junction, which almost completely occluded the bowel lumen. The symptoms were obviously those of chronic bowel obstruction, yet, notwithstanding this fact, the patient, believing she had piles had never thought it necessary to consult a physician for such a trivial ailment.

On the other hand, the disease often exists without producing any symptoms and without the patient's knowledge. This, I have demonstrated many times by examining, as a matter of routinism, cases admitted to the surgical wards of the Hahnemann Hospital, regardless of age, sex or color, for lesions other than those involving the lower bowel and outlet.

The veins surrounding the lower rectum and anus are the ones that enter into the formation of piles. They are subject to frequent dilatation and varices, chiefly for the reasons of their dependent position, their absence of valves, their thin walls (in comparison with their size) and the fact that the walls of the intestinal veins contain few muscle fibres. Another anatomical peculiarity favoring the condition is the manner in which the superior haemorrhoidal veins pass through the muscularis by means of button-hole like slits compressing their walls at this point, thereby inducing venous stasis.

For these reasons, it will be seen that the veins supplying the lower bowel are unable to sufficiently empty themselves and their walls, through persistent over-distention from intravenous pressure, finally become weakened, permanently dilated and varicose. When these pathological phenomena ensue, other morbid changes are inevitable, as the formation of new blood vessels, through hyperemia of the parts and a marked hyperplasia of connective tissue around and between the venous channels. Furthermore, when thromboses of the veins occurs the blood clots may be transformed into fibrous connective tissue as a result of an endophlebitis, terminating eventually in the complete obliteration of their lumen.

From this brief histological description it is evident that haemorrhoids are actual tumor formations composed essentially of two elements,—namely, vascular, consisting of blood vessels, altered in size, shape and consistency, with the formation of new ones, and an abundance of fibrous connective tis-

sue, the latter element not infrequently predominating, especially in chronic cases.

Haemorrhoids are classified clinically into two varieties, namely: external, when located below the sphincter ani externus and covered with skin; internal, when situated within the rectum and covered with mucous membrane. Of the external variety, we have two forms to deal with: The so-called thrombotic and the cutaneous or skin tab. The former is the result of a rupture of an external haemorrhoidal vein with subsequent extravasation of blood into the subcutaneous tissue of the anal margin. The latter is merely a projection of thickened, altered and non-vascular skin surrounding the outlet.

As to the operative treatment of these two varieties, little need be said as both are trivial and the results immediate. The thrombotic pile, having first been anaesthetized by means of a local anaesthetic solution injected into the over-lying integument, is grasped with tissue forceps and excised with scissors curved on the flat, when all blood clots within the cavity are evacuated. Free bleeding may follow which ordinarily stops upon the use of hot compresses and packing the wound with iodoform gauze, though occasionally it will be found necessary to throw a ligature around one or two spurting vessels. As a word of caution, permit me to say that, when working about the rectum, never trust to nature when it comes to hæmostasis, for no matter how trivial the operation, fatal hæmorrhage may occur when the patient is allowed to pass from your observation, unless the bleeding is absolutely checked. The following case will serve as an illustration: A young man was brought to our accident ward by a patrol. He had been operated for a thrombotic pile by a self-termed "non-cutting" pile doctor, and allowed to leave his office with an artery spurting. He collapsed on the street from loss of blood which was so profuse as to soak through his outer garments and to saturate his stockings. His condition upon entering the hospital was so grave that only through the most energetic treatment was his life saved. In every case of thrombotic pile, the blood clot should be evacuated to relieve pain and to prevent the formation of an abscess and fistula.

The cutaneous pile is treated by injecting into its base a local anaesthetic and excising it flush with the surrounding skin. When hæmostasis is secure, dry gauze and a T band-

age complete the dressing both in this and the previous variety.

Internal haemorrhoids are of two varieties, namely, the capillary and venous. The former, while of comparatively rare occurrence and not productive of pain, is a constant menace to good health because of its tendency to persistently bleed. It is readily curable, however, by applying to its surface the actual cautery, or when that is not accessible, fuming nitric acid is a splendid substitute. Previous to the employment of the acid, the anal margin should be smeared with vaseline to prevent the burning of the skin by contact, and following its application a mop soaked in a saturated solution of soda bicarbonate is placed over the area for the antidotal effect. So excellent are the results obtained by these simple measures that one cauterization will usually produce the complete destruction of the pile.

Many operations have been devised for the radical cure of internal venous haemorrhoids, all having for their object either the immediate destruction or removal of the pile tumors; but the two methods that have stood the test of time and are now employed almost exclusively throughout the civilized world are the ligature and the clamp and cautery operations.

The ligature operation has been practiced almost from time immemorial and is one of the oldest operations of which we have any record. As performed by surgeons of antiquity it must have been a very painful procedure, inasmuch as it consisted in having the patient bear down and when the pile came into view a stout ligature was thrown around its base, (in which were included the delicate sensory nerves) tied tightly and allowed to cut its way through the tumor en mass. As performed by modern surgeons, however, the method owes its origin and popularity to the late Messrs. Salmon and Allingham, both of St. Mark's Hospital, London, who modified the technique sufficiently to overcome some of the previous objectionable features. The technique of the operation as performed at St. Mark's and observed by the writer while studying rectal surgery at that institution, is as follows:

The patient having been previously prepared is anaesthetized and placed in the right lateral position, when the sphincters are stretched digitally and all of the piles grasped with forceps. Each tumor in turn is dissected up from its submucous attachment until nothing remains but a narrow pedicle



containing the chief blood vessels that enter the growth from above. The pedicle is then ligated close to its base with a heavy silk ligature and the pile, when of large size, is excised at a safe distance distal to the ligature, or when small, it is allowed to slough off. The success of the operation is due entirely to dissection of the pile, for, if properly executed, a very small amount of tissue remains for the ligature to cut through, rendering the operation practically a painless one and shortening the period of convalescence. This in brief is the ligature operation as performed by English surgeons and is a very excellent and reliable one.

About sixty-five years ago Cussack, of Dublin, originated the clamp and cautery operation, which was later adopted in England by Lee and finally popularized by Henry Smith, of London. The originator of this method employed nitric acid as a means of cauterization, but Smith substituted for it the actual cautery.

The technique of the operation as performed by the writer is as follows: With the patient in the lithotomy position and anaesthetized, the sphincters are slowly but thoroughly divulsed digitally, after which the rectum is irrigated with a carbolic solution through a bivalve speculum and the anal region cleansed with the tincture of green soap and water. By means of hemostats the piles are grasped and a groove is cut in the anal skin at the lower margin of each pile, into which an ordinary straight abdominal clamp is placed and adjusted to the tumor at its base in the direction parallel to the long axis of the bowel. This groove prevents the burning of the skin, oedema of the anal margin and the subsequent formation of skin tabs. All of the pile beyond the clamp is then thoroughly cooked (not merely seared as is done by some surgeons) and the burning is continued until a thick eschar is formed. When all have been treated in like manner, the stumps are smeared with carbolized vaseline and a compress of plain gauze is applied to the external parts, which is supported by means of a T bandage.

The after treatment consists in administering a quarter of a grain of morphine before the patient reacts from the anaesthetic, and applying to the anal region hot fomentations of weak lysol, carbolic or bichloride solution, to be reapplied as circumstances require. The patient is immediately put on a full diet and on the fourth day after operation an injection

of olive oil (6 ounces) is introduced into the rectum and the day following, an enema of soap and water is given through a soft rubber urethral catheter, well lubricated. After the bowels have moved the patient goes about the room and on the seventh day leaves the hospital, although I have frequently allowed them to go home on the fifth day. The stumps are usually entirely healed within three weeks without any treatment, but occasionally it will be found necessary to apply silver nitrate to hasten granulations. My patients are subjected to no preparatory treatment other than to flush the lower bowel two or three hours prior to operation.

In my experience of two hundred and ninety cases of internal venous haemorrhoids, two hundred operated by the clamp and cautery method and the balance by the ligature, the results have been in the highest degree satisfactory. All but two had uneventful recoveries, the exceptions being due to accidental haemorrhage. One from the introduction of a hard rubber syringe nozzle in giving an anema seven days after the ligature operation, which tore off the stump of one of the piles located in the right anterior quadrant. The other occurred in a haemophilic following the clamp and cautery operation. Both, however, recovered.

Comparing the two methods described above for the radical cure of internal venous haemorrhoids, my conclusion is that the clamp and cautery is *the* operation of election for several reasons. It is easier of execution, there is less likelihood of post operative haemorrhage, and last, but not the least important—*the period of convalescence is reduced about one-half*. Furthermore, when I first became interested in rectal surgery and was studying the subject at St. Mark's, London, I was naturally prejudiced in favor of the ligature, for the reason that it was practically the only one performed there at that time and that all others, including the clamp and cautery, were condemned by the surgeons then on service. Upon putting the clamp and cautery into practice however, it was not long when I began to realize that no operation, worthy of the name, was attended with less danger, was surer of results or simpler to perform. The method is applicable to all cases of internal venous haemorrhoids.

**WHAT MAY BE ACCOMPLISHED IN THE PREVENTION AND CURE OF  
DISEASE THROUGH VAGINAL DOUCHE THERAPY.**

BY

SHIRLEY M. LANE, M. D., CHEBANE, ILL.

OWING to the fact that the structural and physiological units and properties respectively, of the body are the elements of health and disease, I will give the histological or minute structure of the parts concerned, together with the function thereof, so that the cause of disease may be readily seen and as readily why the condition is so amenable to treatment in the way of vaginal douche therapy.

*The Vagina:* The vagina consists of a musculo-membranous channel open at its outer end to infection, etc., and at its upper end it is attached to the cervix uteri, its canal is lined with stratified squamous epithelium, without a stroma, resting upon a fibro-elastic submucosa which is very greatly corrugated, thus throwing the surface into many folds.

The vagina is absolutely without glands, though through its limited secretion from its mucous surface it is acid in reaction which protects it somewhat from infection. Surrounding the vagina is the loose pelvic cellular tissue in which is a large blood and lymphatic supply which forms a network especially around the vaginal canal within the submucous coat. At the outer end of the vagina are the glands of Bartholini with their ducts emptying into the vestibule, while the urethra opens just above.

*The Uterus:* The uterus is a muscular organ about three inches long, two inches wide, and one inch thick, though during inflammatory conditions and after childbirth it attains a much greater size. It is composed chiefly of muscular tissue of the smooth muscle type interposed with a limited amount of connective tissue, while its cavity is lined with simple columnar epithelium with numerous branched tubular glands which are also lined by simple columnar epithelium. The epithelium of the uterus is simple, though specialized with cilia, which are hair-like projections from the free surfaces and which have a wave-like motion, causing the secretion from the glands and mucous surfaces, as well as the ova or egg cell to be discharged into the upper end of the vagina through the



opening of the cervical canal, at which point the simple columnar epithelium of the uterine lining changes into the stratified epithelium of the cervix uteri and vagina. Here is a frequent seat of inflammation due to tears of the cervix uteri, etc., which causes ulceration to ensue with closure of the ducts of the glands of Naboth forming cysts, which are sure to break down and form a chronic ulceration of the region, from acrid discharges of the uterus.

The blood supply of the uterus is very extensive, not for the reason the organ needs so great a blood supply during the quiescent stage but chiefly for a physiological purpose during gestation. Its supply of blood is from two sources—the two uterine arteries, one on either side from the internal iliac vessel, and two ovarian arteries one on either side from the abdominal aorta. These vessels anastomose in the uterine mucosa forming dense capillaries which empty into a venous network conducting the return flow.

From the upper and lateral aspect, the tubes one on either side extend outward and downward, making a slight curve forward. Each tube consists of three parts—the isthmus, or the portion joining the uterus, the ampulla or longest and narrow portion of the tube, and the broad termination or end of the tube called the infundibulum, on which project the frimbriae, a single one of which are found on either side to be attached to the ovary.

The ovarian artery is continuous with the tube in the upper portion of the broad ligaments and gives off branches to the tube, ovary and broad ligament, in its course to the uterus. Surrounding the lower region of the pelvic organs is the loose connective tissue which forms the pelvic floor and upon which the pelvic structures are supported. It is very richly supplied with blood and lymphatic vessels.

The etiology or causes of disease:

*Infection:* This is the most common condition we have to treat. Most every woman after having had a miscarriage, or frequently following an ordinary case of labor suffers with subsequent and immediate trouble which may or may not be any more than trivial in character, though at the same time the fire is kindled and a subsequent repetition of the same only adds fuel to the fire which after a period of time causes the condition to become much worse, especially during the life changing period of all women, having left an unhealthy condition of the

uterine lining, the poor unfortunate sufferer becomes a chronic invalid always in distress, or the condition immediately may manifest severe symptoms.

Infection with the venereal diseases may develop independent of the other diseases, and may attack the genitals through exposure to them and a lack of personal cleanliness and become complicated with the germs of pus, since the field is already in a state of adequate preparation for their growth and development. Trauma or injury, such as laceration during labor is another frequent source of the development of infection, especially is this true if the individual be subjected to unsanitary treatment both on the part of her attending physician and herself.

*Abscess.* A cavity containing pus may develop as a result of neglected vaginal douche therapy, especially in the glands of Bartholini or in the pelvic cellular tissue and tubes,

Cancer of the uterus—the most dreaded condition of all—may develop as a result of a tear to the cervix uteri with improper sanitary treatment during the process of repair or of infection stirring up old disease of the cervix where many glands of Naboth have been lacerated resulting in a chronic ulceration. They may also develop from the continued wearing of a pessary, especially has this been but recently impressed upon me. A lady 55 years of age has worn a pessary for five years. I was called to ascertain the reason for pain and slight hemorrhage with a discharge quite pungent and foul smelling which she controlled somewhat by the daily use of vaginal douche therapy. I was somewhat surprised to find that the distal end of the pessary was entirely surrounded with uterine tissue, and a surgical procedure was necessary to remove it. A piece was sent to the pathological laboratory and was found to be a cancer. The lady being unusually strong for her age, I immediately took her to the hospital and through the vaginal route I successfully removed her uterus, since the cancer was in its incipency and free from adhesions no trouble was encountered and the patient made a rapid and complete recovery. The after treatment consisted of vaginal douche therapy with medicated tampons in the vagina which caused complete and thorough healing. The case has been well and no signs of recurrence during the year and a half since its removal.

## TREATMENT.

The value that may be accomplished through the use of vaginal douche therapy is two-fold—the prevention, and cure of disease. I will endeavor to show first how women may readily escape the tortures to which they are subjected through the timely use of vaginal douche therapy.

The value of this simple and markedly wonderful treatment has its motto in five words: "*Fresh pure blood cures disease*" (Dr. Byron Robinson). Never in the study or practice of medicine have I discovered a man who was as faithful or who even used vaginal douche therapy as did Dr. Robinson, and being associated with him two years in his Chicago clinics, I congratulate myself on having had the opportunity so greatly missed by numerous practitioners, who through their lack of this clinical evidence, fail to use vaginal douche therapy where many a life might have been made a pleasure to endure or have been spared from the surgeon's knife.

In the beginning of the life of a woman, say the age of fifteen or sixteen, she has just started to menstruate, has pain almost constant and unbearable, scanty or profuse discharge which may or may not be associated with clots, usually, however, clots are present. Taking it for granted or being assured she has always led a life, simple and virtuous in regard to the region in question and had always been free from venereal disease or infection, what is her trouble? Upon examination it is found that she is anemic, her blood sometimes is as low as 70 per cent., and a vaginal examination reveals a uterus much under size, why should she have trouble? Simply her age has developed where she should menstruate before nature has properly prepared the field.

Her menstrual organs are still in an infantile state, not matured, consequently, should she go on unassisted, she will never reach the end of her misery and will be obliged to remain home, away from her duties and often remain in bed during the menstrual period. When she reaches the age of forty-five or fifty, she will be a chronic invalid or must go through a surgical procedure to continue her remaining years with pleasure; usually, however, she will have been operated before the life changing period, whereas if she had been treated with vaginal douche therapy when she first complained, the results would have been thus:



The medicated water of the douche should be as hot as the patient can endure, several quarts should be used, and with the Marvel spray the douche is given three times a day, as follows: The syringe nozzle is introduced into the vagina and the contents expelled, drawn back into the bulb and repeated several times and thrown away, and so on until the entire amount is used, the results being numerous:

1. Tonic stimulation or massage which is induced by the force exerted by the action of the bulb.
2. Stimulation of the circulation, causing more blood to flow to and through the region in question.
3. Stimulation of the glands and mucosa of the uterus and adnexa.
4. Stimulation and growth of the ovaries.
5. Growth of the uterus.
6. Restored functional conditions, thus restoration of the normal menstrual cycle.
7. Reflex symptoms of headache, backache, constipation, etc., disappear.
8. Restoration of general health.

How and why the results are as stated can be readily seen. By causing more blood to flow through the part concerned it becomes stronger, and is better able to take care of the duties connected with it, much the same way, for example, as does the blacksmith's arm under the strain to which it is constantly subjected, more blood is being driven into it and it grows, gets larger and stronger and more readily performs the task before it. All these results are brought about by the fresh, pure blood which is caused to traverse the afflicted organs, by means of the massage and heat of the vaginal douche therapy.

This procedure, consisting of three douches a day for a period of time, becomes rather monotonous, especially should the patient fail to see any improvement at her next menstrual period; however, this should not ensue as the work of years can not be mended in the course of a fortnight.

I have seen several cases after two or three months of such disappointment and worry, under my request to continue become suddenly surprised at the following period to be unable to note its arrival or disappearance only for the inconvenience it causes otherwise.

Now, for illustration, I will cite a case where disease had paved its way: A woman aged fifty, and a mother of nine chil-

dren, had, she thought, passed the menopause, since she had failed to menstruate for a year previous, until three months ago, when she began having irregular scanty hemorrhages with more or less pain. When I was called she had been menstruating more or less profusely for twenty-seven days. She was under local treatment from her family physician, consisting of medicated tampons, and continued such without any improvement, being of the belief that I, being a surgeon, would suggest a surgical procedure immediately, but after twenty-seven days without the slightest improvement, in fact being much weaker, etc., she gave up in despair and sent for me and was very much surprised when I failed to mention surgery. But instead I put her on a reconstructive tonic, controlled the profuse flowing from the genitals by means of internal medication and started her on vaginal douche therapy.

She was very much weakened and unable to leave her bed. Analysis of the blood showed it to contain 60 per cent. coloring matter, 3,000,000 instead of 4,500,000 or 5,000,000 red cells to the cubic millimeter of blood, and only 5,000 white cells to the cubic millimeter of blood showing a very low resistive power. There was loss of appetite, constipation and general debility. Examination of the generative organs showed the following: A much enlarged and tender uterus, an inflammatory mass involving both ovaries and tubes which was so tender it could hardly be palpated and there was a profuse bloody discharge, at times containing portions of the uterine mucosa.

After two weeks of tonic and vaginal douche therapy her blood tested 80 per cent., her uterus became smaller and less tender, but the inflammatory masses surrounding and involving both ovaries and tubes were about the same, her varied train of symptoms had somewhat lessened and the flowing had entirely ceased on the fifth day. At the end of three weeks her blood tested 90 per cent. The uterus was about the normal size and without any appreciable tenderness, and the size and tenderness of the pelvic inflammatory masses had also greatly abated, and at the end of the fourth week there were no clinical evidences of disease, no masses to be found, neither were there pain nor tenderness to be elicited by the ordinary pressure exerted during palpation or otherwise and she was up and around doing her usual duties, saying, "I have never felt as well in years."

Another very similar case was one with irregular menstrual symptoms after having passed the menstrual period: At age of fifty, there was pain, distention, constipation and general debility, temperature of 102, when one of these attacks came on. An examination revealed an enlarged and irregular uterus and a bilateral inflammatory mass involving both tubes and ovaries which could not be palpated without first putting the patient to sleep, which I did, and found that she not only was suffering from these inflammatory masses, but that she also had multiple fibroids of the uterus.

I recommended a surgical procedure for the removal of the fibroid uterus but advised first the treatment of vaginal douche therapy for the inflammatory masses, since the operation for removal of the uterus and adnexia is serious enough in itself, let alone being complicated with infected tubes, etc., in conjunction therewith to add more trouble to the case.

At the end of three months of vaginal douche therapy treatment I made an examination and found the inflammatory condition entirely abated and I could readily detect the multiple fibroid condition of the uterus. The following week I operated, doing a supra-vaginal hysterectomy, removing a fibroid uterus which was very irregular owing to the fact that it contained twelve fibroid tumors and weighed four pounds, while the only evidence of an inflammatory reaction was the presence of a few adhesions to the tubes and ovaries, which were rather small owing to the age of the patient and the nature of the treatment. Post-operative treatment consisted of vaginal douche therapy three times a day for three weeks, the patient making a complete recovery.

Time and space will not allow me to tell the good things that have been done and can be accomplished with this wonderful procedure, since its application is not only indicated in disease but in the prevention of such, especially so in the personal cleanliness of women when they are afflicted with leucorrhœa, etc., and are exposed to infection or to the causes, which cause the condition to grow worse.

The treatment is so simple and easy of application that no woman, young or old, should be without a convenient vaginal spray in her home at all times, since through its use woman's health is preserved and many a woe made to vanish.



**BUREAU OF SANITARY SCIENCE**

HOMOEOPATHIC MEDICAL SOCIETY OF THE STATE OF  
PENNSYLVANIA.

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G. J. BERLINGHOF, M. D., Chairman

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**THE PREVENTION OF TUBERCULOSIS.**

BY

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VARIOUS methods have been adopted by the different States for the State control of tuberculosis. Many of our larger cities have established municipal institutions for treatment of the disease and have adopted local measures for its prevention. The U. S. Government has placed a barrier on the immigration of tubercular foreigners as nearly one-half the cases diagnosed in this country are foreigners. Much has been done throughout the country for the elimination of tuberculosis from dairy cattle, and many States have passed laws having as their object the control of bovine tuberculosis.

In some places, provision has been made against the transportation of bovine tuberculosis to human beings by the consumption of milk and there is a general provision in the laws regulating meat inspection against the transmission of bovine tuberculosis to human beings through consumption of meat. The whole country is now alive to the importance of stamping out tuberculosis, and our people and our governments, local and general, are vieing with each other to accomplish something in the great cause.

From a recent report of the national association for study and prevention of the disease, there are in existence in the United States at present 360 associations for the study and prevention of tuberculosis, 380 dispensaries for the treatment, and 400 sanatoria and hospitals for the treatment and care of patients. The hospitals have a capacity for 17,890 beds.

Conservative legislation is necessary for successful campaign against tuberculosis, because in the newness of the subject the principles underlying prevention as they bear upon the customs and habits of the people have not yet been embodied in our

laws. What the government does should be done by due process of law. Registration, for example, is essential for a logical campaign against the disease, and registration can only be established by legal enactment. Compulsory isolation for irresponsible, malicious consumptives who are either incapable or unwilling to do those things which are necessary for the protection of others, should be provided by law. It is as important in the interests of public welfare as the incarceration of persons who endanger the lives of others by physical force. The improvement of housing conditions, working conditions, and the protection of water and food against the disease producing contamination should likewise be provided by law.

It is doubtful if tuberculosis can be contracted from expectoration on the street, also whether human beings can be infected with bovine tuberculosis. The chief value in stopping spitting on the street lies in teaching people not to spit at all, except in receptacles in which sputum can be controlled and destroyed; but to stop spitting by education, so that people can understand the reason for it and to stop it by law without understanding and with the feeling of resentment against the law and against the cause which has given rise to the law is another thing.

The dispensary, with its various modifications, appeals to one very strongly as an asset for the prevention of tuberculosis, because it deals with a large number of people. As usually conducted with assistance to the poor in food and preventive measure supplies, it is attractive to those people whom it seeks to help and bring them under observation. The dispensary gains admission into the homes of consumptives and serves the purpose of education better than any other measure which has been devised, not so much on account of cures that are made as from an educational and sanitary standpoint. It also constitutes a clearing house for sanatoria and hospitals. For these purposes it is essential for the crusade against tuberculosis and money expended upon it is well spent. Especially is this true in this State, where the consumptive is followed to his home by a trained nurse, whose duty it is to ascertain whether or not the patient is able to procure their own milk and eggs, and if not, provide them; this done she teaches the patient and the family how not only to take the best possible care of the afflicted, whether they be ambulant or bed-ridden, but the remainder of the family how to prevent further spread of the disease. They

are required to attend class once each week, where they are told how prophylaxis and treatment are to be carried out and are permitted to ask any questions they see fit. A record is kept by the patient on which is recorded the temperature, the number of eggs taken, the amount of milk, the number of hours spent at rest in the open air and the number of hours slept. These all aid in the management of the case.

The sanatorium even more than the dispensary appeals to one very strongly as a measure for the prevention of tuberculosis. It probably has won more public support for the crusade than any measure that has been produced. It appeals to one because one can see results from it. It moreover has a bright human side to it, because restoration of a sick person to health brings happiness and satisfaction to all concerned.

The work which is accomplished in sanatoria is unfortunately deceptive. Patients as a rule, in the early stages, get well, and were it possible to limit the uses of sanatoria to such cases the final result would be better. As things are, many who go to sanatoria have already reached the open stage of the disease; and while they are restored to physical health, in the end the majority of them have relapses and go to a fatal termination. The time when they become intensely contagious and implant new cases is merely postponed, for ultimately they produce the most favorable conditions for implantation just as they would have done had the disease been allowed to run its course in the beginning. For these reasons the sanatorium is not a first-class preventative measure, although better than the dispensary. It is only when the sanatorium restores to perfect health, from which there is no relapse, that it does real preventative work.

Isolation and control of the tuberculous subject in acute conditions and during the advanced period of his disease, undoubtedly constitutes the most efficient measure for prevention for the disease. Universally applied it alone would wipe out the disease in a relatively short time. Strange to say, it has received less attention than any of the measures which have been introduced, probably because it is less attractive. The time has come, however, when the scientific world is beginning to realize its importance, and everywhere advanced thought demands that it should be given the preference over all measures. We have both reason and experience for this.

In the light of the knowledge about tuberculosis which has accumulated since Koch discovered the bacillus, we are justified



in assuming for practical purposes that tuberculosis is rarely implanted except during advanced stages of the disease, and that then, unless proper precautions are taken, it is almost certainly implanted in every one who lives in the enclosure which confines the stricken individual. Tuberculosis is practically always a houseborn disease and even in the house the contagion must acquire a certain potency before implantation can take place.

Every one has resistance to a certain number of bacilli and this resistance grows with exposure to the disease so long as the exposure is below the potency for implantation. Contact with consumptives, therefore, does not necessarily lead to implantation at all times, but only when the number of bacilli taken overcomes the resistance of the individual exposed. The time when this is most likely to take place and the place where it is most likely to occur are in the homes of the dying consumptive during the last few months of life, when sorrow and want and watching help to break down resistance and make it easier for implantation to occur. Careful examination of the families in which an advanced consumptive exists under the same roof has shown that most of the members of such households have had implantation and where they have been watched over a long period of time, in some instances, all have gone under with the disease one after another, as resistance broke down. Even the children in households in which an advanced consumptive exists have been found to react to tuberculin when they have no other discernible indication of tuberculosis. Statistics on implantation show that vastly the majority of the cases in which a history of contagion can be made out, have come from close contact with an advanced case, for a long period of time in family relationship.

By stamping out tuberculosis the hospitals for advanced cases undoubtedly will have to be depended on. All other measures will only play a secondary part and should be viewed as aids in a well organized plan of campaign. When possible the campaign should be begun with caring for patients in the advanced stages.

History shows us the preventive value of caring for patients in advanced stages. In 1782, the kingdom of Naples, then under direct control of Spain, from which it absorbed its idea of contagion of consumption, enacted severe laws for the prevention of tuberculosis by isolation. What we now know as

tuberculosis was then not recognized and only the open stage of the disease then and now known as consumption was provided for in the law. Every case of consumption had to be reported by either the physician or the family under the penalty of fine, imprisonment, or service in the galley, and when reported, isolated either in the home or the hospital. When done at home everything which belonged to the patient was sealed up by a magistrate, and the individual infected was confined to one room. Many patients were removed to hospitals. After death the premises in which a consumptive had been confined was thoroughly cleansed and what could not be cleansed was destroyed by fire. Houses in which consumptives had been isolated had to be renovated, in fact almost rebuilt, and the belongings of the consumptive had to be disinfected or destroyed. When this law was enacted tuberculosis was a plague in the kingdom of Naples and assumed most malignant forms. In less than a century, under the administration of the law, tuberculosis became so rare that the law was repealed and physicians gave up the idea of the contagiousness of the disease.

Later we have an equally striking demonstration in another way of the value of isolation for prevention. In the beginning of the 18th century a movement was started in England. England did not believe in contagion at that time and there was no purpose of prevention. The first hospital for scrofula was founded in 1790, but early in the following century a hospital was opened for advanced consumptives. Once started the hospital spread rapidly and one after another large institutions sprang up and so many applications were made for beds that if an applicant was further advanced than an inmate, he was compelled to give up his bed to him. The result was a 75 per cent. reduction in the next century.

In contrast with the work done in England stands the work done in France, where the advanced cases were ignored entirely and all the attention and treatment given to infected children, where the idea prevailed that by building up the children they would develop into healthy adults. They built them up only to be infected later. In the beginning of the 19th century the death rate from tuberculosis in London and Paris were equal, now Paris has a death rate from tuberculosis four times as great as London.

The lesson which is taught us by isolation in Italy and in England is confirmed by a study of work done in the crusade

against tuberculosis in every part of the world where anything has been done. In Germany there has been a rapid reduction in the death rate in recent years, concomitant with the isolating capacity which the German hospitals and sanatoria have developed; but more work has been done in sanatoria than in hospitals, and the shortcomings of sanatorium work as compared to hospital work for preventive purposes can be traced in the results. Germany is beginning to realize this and its foremost men are agitating isolation of the patients in advanced stages. Koch shortly before his death came out strongly for isolation of advanced cases.

In the United States, Massachusetts, perhaps the first to see its error in expending its resources for patients in the early stages, has taken steps to make provision for patients in advanced stages on a large scale. It has established one large hospital for this purpose, and is about to establish another. New York City has also realized the importance of providing for patients in advanced stages and is expending vast sums of money for this purpose. Philadelphia has so far devoted practically all its resources for this purpose, to the care of patients in advanced stages. Pennsylvania is caring for its advanced cases at Mt. Alto, but only those without relatives or friends are willing to go so far away from home. Pittsburgh has recently set aside a large sum of money for that purpose and will soon build a hospital to look after its own advanced cases.

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**PULSATILLA.**—Acute and subacute forms of frontal sinusitis have yielded quickly to the action of pulsatilla. A lady suffered a month with frontal sinusitis, the antrum also being involved. Pain, redness and sensitiveness over the bones were intense. After a month of allopathic treatment, during which time anodynes were administered, the case was cured in three days with Pulsatilla. The remedy was prescribed, not so much on its objective indications, as upon the natural affinity that Pulsatilla has for the parts involved.—(*Jan. Century*).

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**CAPSICUM.**—Capsicum is the remedy in relaxed sore throat. The fauces and pharynx are dusky red and the uvula elongated and œdematous. It is specific in the early stages as a gargle, one dram of the tincture to half a pint of water. The throat of capsicum is red but has *more burning* and stinging pain and less febrile disturbance than belladonna. The faucial tissues are more baggy.

Here we have burning in fauces, parts most sore and tender, ulceration presents sharply defined ragged edges with indolent adjacent tissue. It is a potent remedy for the cure or mitigation of pellagra.—*Pacific Coast Journal Homceopathy*.



**SOME CLINICAL OBSERVATIONS ON CACTUS, CRATAEGUS AND THE  
IODIDE OF ARSENIC IN THE TREATMENT OF  
DISEASES OF THE HEART.**

BY

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(Read before the Maryland Homoeopathic Medical Society.)

THE treatment of patients suffering from diseases of the heart occupies an increasing portion of the time and thought of the general practitioner of medicine and of the internist. The increase in the number of persons suffering from circulatory affections cannot be traced to the acute infectious diseases, which are markedly on the decline, but in my opinion is the result of modern methods of living and of working. The up-to-date business man seldom rests. From the time he leaves his home in the morning until he retires to bed at night his mind and body are subjected to constant activity and strain. Periods of relaxation or of repose are not to be thought of, and as a result a severe tax is placed upon the nervous and circulatory systems. Hence the "successful" American business man at forty-five with his nervous breakdown, his chronic Bright's disease, or his degenerated heart and arteries.

The era of hopeless prognostications regarding patients suffering from diseases of the heart is fortunately passing away. Inaugurated by the postmortem pathologists, who pointed to a distorted valve or a spot of degenerated heart muscle and defied the clinicians to restore them to their original state, this era of pessimism and of therapeutic nihilism held absolute sway among the dominant school of medicine for more than a decade, and few practitioners of any school dared to speak positively of the therapeutic value of drugs in the treatment of cardiac diseases without fear of being accused of exaggeration or of unscientific observations.

Fortunately for the medical profession, recent physiological researches have revealed the marvelous reparative powers of the human heart, and have demonstrated that even in the presence of a distorted valve the heart may maintain a normal circulation, and that, while we cannot replace a degenerated

bit of muscle fiber in the heart, we can so improve the efficiency of the remaining muscular tissues that the weakness of a portion can be completely compensated for. In other words, by proper therapeutic measures the heart may be put in such condition that it is able to maintain a normal circulation, and thus perform the function for which it was intended. The fact that a trill or murmur may be produced in the performance of this function is of little consequence to the patient.

A study of the physiology of the heart shows that the most important factors in the maintenance of a normal circulation as far as the heart is concerned are the nervous mechanism of the heart and the tone and power of its muscular tissue. As Stokes, and more recently Barker, of your own city, have pointed out, the maintenance of the tone and power of the heart muscle is the very essence of cardiac therapy. Any agency, therefore, that is capable of exerting a regulating influence upon the nervous mechanism of the heart, or of improving the nutrition and power of the heart muscle, may be reasonably expected to prove of therapeutic value in assisting a disturbed heart to perform its function normally and satisfactorily.

I have made the foregoing remarks for the purpose of showing that the beneficial results which clinical experience has demonstrated follow the administration of properly selected remedies in the treatment of diseases of the heart are not out of accord with the results of recent scientific research.

#### CACTUS GRANDIFLORUS.

The first remedy to which I wish to refer is *cactus grandiflorus*. There has been a good deal of dispute of late among pharmacologists as to whether or not this drug exerts any physiological effect upon the heart or vascular system. With this, however, we are not chiefly concerned. What we, as physicians, want to know is whether patients suffering from cardiac diseases are benefited by the administration of this remedy. Clinical observations in numerous cases that were followed over a period of several years compels me to believe that it does produce positive therapeutic effects.

The value of *cactus* as a cardiac remedy was forcibly brought to my attention by the late Dr. E. R. Snader, whose experience with it was very extensive. I have had the opportunity to ex-

amine many cases that were under Dr. Snader's care, to whom this remedy was administered, and for the past six years have used the drug very extensively in my own practice. My observations lead me to believe that the drug is of decided therapeutic value only in the following conditions:

*First:* Nervous affections of the heart, whether they are the result of overwork, worry or mental disturbances. The heart is irregular in rhythm, and its rate varies under the slightest mental or physical disturbance. A number of sensory disturbances are frequently present; the sensation of a constricting band around the heart being a well known indication for the use of cactus. It is a mistake to believe, however, that cactus is only useful when this symptom is present. More common still in the cactus cases there will be pricking and shooting pains in the precordial region associated with tenderness to pressure in the intercostal spaces of the third, fourth and fifth ribs. Pain of this nature is frequently believed to be due to angina pectoris, but such is rarely the case. It is usually the result of disturbances in the intercostal nerves supplying the precordial region, and I agree with McKenzie in the view that it is the result of a viscero-sensory reflex, indicative of fatigue of the heart muscle. Fluttering or palpitation of the heart, aggravated by mental excitement or when lying on the left side, is another symptom frequently present. Numbness of the left arm is another condition that I have frequently found to be quickly relieved by the administration of cactus.

*Second:* Mild degrees of cardiac insufficiency, especially when the result of rheumatic endocarditis. In such conditions, particularly if associated with the accompanying sensory disturbance referred to above, cactus combined with the proper amount of rest, is a much safer and more efficient remedy than digitalis. In this group of cases there is usually some oppression of the chest and difficulty in breathing, but not the marked dyspnoea and general dropsical condition commonly found where digitalis is indicated.

#### REPORT OF CLINICAL CASES.

CASE I: *Cardiac Neurosis. Paroxysmal tachycardia.* Miss K., age twenty-five. German descent. Occupation, housework. The patient at the time of my examination was in good general health and had never suffered from any serious illness.



For the past six months she had suffered from severe attacks of tachycardia. These attacks would come on suddenly and would be accompanied by a severe throbbing sensation in the heart and a feeling as though the heart would burst. The pulse rate varied from 180 to 200 per minute; the attack would last from one-half to one hour and would leave the patient weak for several days. In the intervals between the attacks the patient suffered from pricking and burning pains in the region of the heart and said the heart felt as though it were sore. The attacks seemed to be induced by any nervous or mental excitement. Gelsemium 1x gave prompt relief during the attacks but had no effect in diminishing their frequency. I then prescribed the tincture of cactus, five drops four times a day, to be taken between the attacks. After this remedy was started the patient had one attack which was quite mild. For the past eighteen months she has had no further attacks and the pulse is perfectly normal in its rate and rhythm at all times.

CASE 2: *Organic Heart Disease—Mitral regurgitation.* Mrs. J., age forty-two. The patient was in good health until eight years ago when she had an attack of rheumatic fever which was followed by acute endo-carditis. When the endo-carditis subsided the patient was found to be suffering from mitral regurgitation. For four or five years she suffered almost continually with a sensation of soreness in the precordial region which at times became aggravated and gave rise to sharp, stinging pains < on the least exertion. There was marked shortness of breath and considerable debility and the patient was unable to attend to any duties in her home. She was prescribed for a number of times by an old-school physician who gave her iron, arsenic, strychnine and other tonics but she made little or no improvement.

In March, 1909, she came under my observation and her condition was one of semi-invalidism. The sphygmographic tracing of the pulse showed it to be irregular as well as weak and rapid. (See Fig. 1.) Cactus tincture, five drops four times a day was prescribed and continued for twelve months.

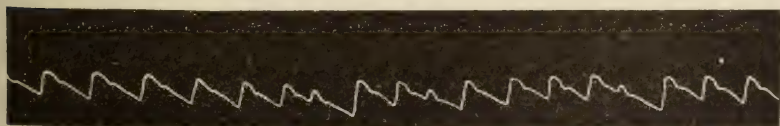


Fig. 1.—Mrs. J. Showing the condition of arrhythmia existing before Cactus was given.

At the end of that time the patient was materially improved both as regards her cardiac condition and her constitutional state. The pulse had become regular in rate and rhythm (See Fig. 2); the shortness of breath had cleared up almost entirely and the patient had gained twelve pounds in weight.

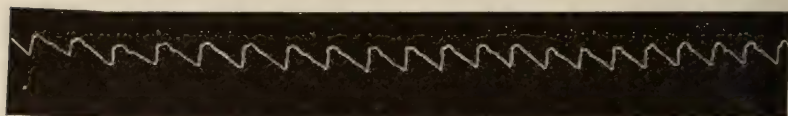


Fig. 2.—Mrs. J. Showing the condition of the pulse after the administration of Cactus.

I had occasion to examine her a few weeks ago and she claims that she feels better than she has felt for many years. She has taken the cactus at intervals during the past two years when any discomfort was felt in the region of the heart or signs of returning debility were present.

Cactus is a remedy that should be administered for a long period of time in order to obtain lasting results. It is not a rapid cardiac stimulant, but a mild tonic to the muscular and nervous mechanism of the heart. I have seen it taken for a period of many months almost constantly with the most favorable results, especially in people past middle life who suffer from impaired circulatory power, the result of valvular heart disease following infectious diseases in earlier life. My experience has been almost entirely with the tincture, which I administer in doses of five to ten drops three or four times a day.

#### CRATAEGUS OXYCANTHUS.

This remedy is one that has received very little attention in homœopathic literature, and yet it has an important place in the treatment of both functional and organic diseases of the heart. Few provings have been made on healthy subjects, and most of the indications are clinical ones. The best effects from crataegus are obtained in cases of rapid heart of nervous origin, in mild degrees of dilatation, and in the earlier stages of myocardial degeneration. Irregularity of the heart is invariably present when crataegus is indicated; and a symptom that I have seen verified in several cases is a *painful sensation of*

pressure in the left side of the chest below the clavicle. In one case in which this symptom was so marked as to suggest the probability of an aneurism, crataegus gave prompt and permanent relief. Shortness of breath on exertion and marked mental and physical fatigue are also present. Oedema of the lower extremities may be present, but is usually moderate in amount. Ellingwood has reported its favorable influences in cases of valvular disease with slight dilatation, and in cases of arterio sclerosis with beginning dropsy. In angina pectoris with aortic regurgitation it has proven a most efficient remedy. He further states that it is sometimes efficient in relieving painful affections of the heart where cactus fails. This statement I can verify from my own experience in a number of cases.

To sum up, the important subjective symptoms calling for crataegus are rapid, irregular pulse accompanied by palpitation and extreme mental and physical weakness on exertion; in conjunction with this are painful sensations in the region of the heart, and particularly a painful feeling of pressure below the left clavicle. I usually employ this remedy in five drop doses of the tincture three or four times a day.

#### REPORT OF CLINICAL CASES.

CASE I: *Cardiac Neurosis. Palpitation.* Mr. S. Age thirty-two. Has usually been in good health, his only illness being scarlet fever at ten years of age. For the past two or three years has felt very nervous and irritable. Recently he has noticed considerable lassitude and weakness with a jerking sensation in the region of the heart. The heart feels as though it would jump out of his chest. The patient's hands and feet are cold and he suffers from vertigo after exertion. The jerking and jumping sensation in the heart has caused him a great deal of anxiety and states that he is unable to sleep or work on account of the mental and physical distress resulting from it.

Examination showed the heart to be irregular in action and

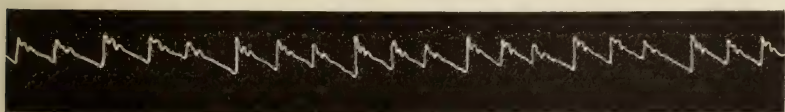


Fig. 3.—Mr. S. Showing rapidity and irregularity of the pulse at first examination.



rapid (100 per minute), and his weight to be 134 pounds. The patient had been under treatment for the previous two years with no improvement. Crataegus was prescribed in ten drop doses of the tincture three times a day.

An examination one month later showed the heart to be regular in rate and rhythm, and the jerking and throbbing sen-

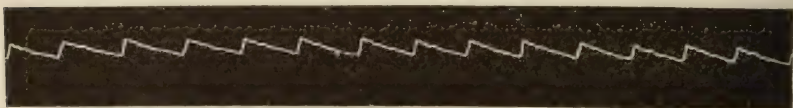


Fig. 4.—Mr. S. Showing normal tracing following the administration of Crataegus.

sation in the region of the heart had entirely disappeared; the mental anxiety was much diminished. Two months later the patient said he considered himself entirely well. He had gained eleven pounds in weight, was sleeping and eating well and complained of no abnormal sensations in the region of the heart.

*CASE 2: Organic Heart Disease. Mitral Stenosis and Myocardial Degeneration.* Mr. S.—Health good until twenty-three years of age, when he had typhoid fever from which he made an apparently good recovery.

About three years ago began to notice that he was losing his strength; would become exhausted after very slight exertion. He also stated that he would grow short of breath, at first, on going up stairs, but later on walking on the level. A physical examination showed the heart to be enlarged one inch beyond the mammary line and auscultation revealed a pre-systolic murmur at the mitral area accompanied by a decided thrill. The pulse was irregular in rate and in force. Its rate was 96.

When the patient came under my observation, in addition to marked lassitude and shortness of breath on the least exertion, he complained of a feeling of fullness in the region of the heart accompanied by a sensation of pain which was not severe but rather dull and constant. This pain was worse after eating.

He had been under old-school treatment for several months and had received principally digitalis, which was productive of no improvement. I prescribed tincture of crataegus, ten drops three times a day and advised the patient to rest in bed until his condition improved. This he refused to do but continued his work which was of a clerical nature. Nevertheless he showed decided improvement and after six weeks' treatment his pulse

became normal in rate and much improved in force and regularity.

The patient continued to improve and at the end of six months had regained a fairly comfortable state of health.

Against my advice he discontinued treatment and I did not see him again for almost a year. He then came to my office suffering from a severe attack of bronchitis with marked dyspnoea and cyanosis. He stated that he had contracted bronchitis four weeks before and had been under old-school treatment, receiving expectorants and digitalis. His condition was quite serious and I urged him to go to bed until the compensation of his heart could be restored. This he again refused to do and the following day developed an infarct in the right lung; this was followed by an embolus in the brain from which he died two days later.

#### IODIDE OF ARSENIC.

There are few remedies that have a wider range of applicability in chronic cardiac diseases than the iodide of arsenic. Its value lies in its power of modifying the nutrition of the individual cells, and to its ability to improve the nutrition of the heart muscle. The cases in which it may be used with benefit therapeutically may be conveniently considered under the following headings:

*First.* Functional disturbances of the heart, the result of anemia and general debility. These conditions are frequently met with in young women, and in individuals recovering from acute infectious diseases. The patient is pale, poorly nourished, thin, and tires easily on exertion. Subjective symptoms, as far as the heart is concerned, are comparatively few,—the most common being palpitation on exertion. On auscultation with the ear or stethoscope a soft, blowing murmur is frequently heard at the base of the heart, the result of loss of tone in the papillary muscles. In such conditions the administration of the iodide of arsenic, combined with fresh air and a nutritious diet, is productive of immediate and striking results. The patient improves in weight and strength, the heart becomes slower in rate, and the murmur entirely disappears. Another remedy of importance in similar conditions is iron.

*Second.* Chronic valvular affections of the heart which have led to hypertrophy and beginning dilatation.

It is a well known fact that the most serious results of

chronic valvular affections are those resulting from impairment of the nutrition of the heart muscle. We should, therefore, be on the constant watch in patients with a compensated valvular lesion for the early signs of failing compensation. With the onset of these signs, namely: a general weakness and lassitude; shortness of breath, swelling of the feet, etc., the iodide of arsenic should always be thought of as a suitable remedy. The marked sensory disturbances that are present when cactus or crataegus are called for, are frequently absent. The constitutional symptoms are most important in guiding us to the selection of this remedy, namely: weakness, anaemia, loss of weight and decided gastro-intestinal irritability.

*Third.* Chronic myocardial degeneration whether primary or secondary to valvular disease. In this very common and very serious disorder of the heart the iodide of arsenic stands as our sheet anchor. It far surpasses digitalis in its utility in these cases provided marked rupture of compensation has not occurred. The patient in which its typical indications are present is thin and emaciated in spite of good food and care, and impresses us as being worried and prematurely aged. The pulse is weak and irregular, and the arteries are frequently thickened by the formation of fibrous tissue. Examination of the heart usually shows some enlargement with a weakening of the muscular element at the apex. The circulation in the extremities is poor, hands and feet are cold, and the patient tires readily on exertion. Oedema may be present, but is usually not marked. The power of the iodide of arsenic to prevent the progress of the degenerative process and add to the comfort and life of these patients cannot be doubted by any one who will give it a fair trial. I usually employ it in the second decimal or third decimal trituration, giving one grain three or four times a day for one month, and then discontinuing for two weeks, and repeating another month.

If we are to obtain the best results from the iodide of arsenic I believe that the method of preparation is of importance. As ordinarily prepared by homœopathic pharmacists the iodide of arsenic is mixed with sugar of milk and triturated in an open mortar for four hours for the first trituration, and two hours each for each succeeding trituration. Those of you who have made a study of this substance know that the iodine is in rather loose combination with the arsenic, and under the influence of trituration when exposed to the open air the iodine is readily



liberated and the arsenic is left behind. For the past three years I have abandoned the use of triturations of iodide of arsenic made in this way, and my results under the method which I now employ have been so far superior to those formerly obtained that I desire to commend it to your consideration. I direct the pharmacist to add one part of Merck's chemically pure iodide of arsenic to nine parts of sugar of milk, and triturate in a mortar in a somewhat darkened room for ten to fifteen minutes. From this the second decimal trituration is prepared by adding the proper quantity of sugar of milk and triturating for fifteen more minutes. The trituration is then put in gelatine capsules and kept in a dark glass bottle away from the light. I have used black capsules at times, but find the ordinary gelatine capsules kept in a dark bottle answer the purpose just as well. Prepared in this way the drug is thoroughly mixed with the sugar of milk, and yet is not triturated long enough to lose its proper proportion of iodine.

#### REPORT OF CLINICAL CASES.

*CASE 1: Organic Heart Disease. Mitral Regurgitation with Dilatation of the Heart.* Miss W. Age twenty. Six months ago suffered from a mild attack of rheumatic fever after which she returned to school and climbed up several flights of stairs daily. After a period of two months she began to grow very short of breath and became markedly debilitated. A physician was called (old-school) and treated her for several months, but her condition remained the same.

On my first examination of this patient, I found her sitting in a chair very short of breath and markedly emaciated; her pulse was irregular and rapid (110 per minute). The feet were oedematous and an examination of the heart revealed a loud murmur at the apex systolic in time, transmitted into the axilla; the heart was enlarged one inch and a half beyond the mammary line. The patient was put to bed and digitalis was prescribed in ten drop doses of the tincture four times a day. This failed to give her any relief and after ten days it was discontinued and the patient was put on stropanthus. This remedy acted favorably almost at once and at the end of ten weeks the patient was able to sit up. She was much improved but still in a very weak and debilitated condition. The remedy was continued for a reasonable time, but while the heart remained fairly good and the oedema entirely disappeared, the general condition of the patient remained very unsatisfactory.

On account of the weakness, anaemia and emaciation, together with the poor state of nutrition of the heart muscle, I prescribed the iodide of arsenic 2x, one grain four times a day. In addition the patient was given three raw eggs and a moderate amount of milk daily in addition to her regular diet. From that time improvement was gradual but steady and six months later the patient was able to resume her ordinary duties and was free from any discomfort except some shortness of breath on exertion.

I had occasion to examine this patient four years later and, with the exception of the murmur which is still present, found her to be in excellent health. She has gained about twenty pounds and takes charge of the work in her home without any discomfort whatever.

*CASE 2: Organic Heart Disease. Myocardial Degeneration. Arterial Sclerosis.* Miss S. Age 75. This patient came under my observation four years ago and complained of great weakness which made it very difficult for her to walk; shortness of breath and oedema of the lower extremities extending up to the knees. The heart was rapid and the sounds were very weak. The arteries were thickened by the deposit of fibrous tissue. I gave a bad prognosis and advised that the patient be put to bed. She refused to consent to this part of the treatment. I prescribed iodide of arsenic, 2x trituration, one grain every three hours. Very much to my surprise she began to improve and by the end of four weeks the oedema had entirely disappeared and her general strength was much better.

This patient is still living and when I had an opportunity to examine her a few days ago, I found her free from oedema and quite comfortable in every way except for the weakness incident to her age. The heart was somewhat rapid but regular and she is able to do a considerable amount of walking without any special discomfort. The arterial sclerosis and the degeneration of the heart muscle of course persist, but I believe that the use of the remedy has prolonged her life.

In closing this rather fragmentary paper I desire to state that my purpose in preparing it has been to call your attention to the following conclusions:

*First.* That recent investigations in physiology of the heart have shown that there is much room for optimism in the treatment of cardiac diseases.

*Second.* That in the homœopathic materia medica we have a number of remedies, three of which I have just cited, that are of unquestionable value in modifying favorably the nervous and muscular structure of the heart.

*Third.* That the practical results of the administration of these remedies in patients suffering from cardiac affections show that they are capable of producing a complete cure in functional disorders of the heart, of restoring to a life of comfort and usefulness patients suffering from milder degrees of cardiac insufficiency, and of adding to the comfort and longevity of patients affected with the more serious forms of cardiac disease.

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### A CASE IN WHICH LACHESIS WAS PRESCRIBED.

BY

GEORGE W. MACKENZIE, M. D., PHILADELPHIA.

PATIENT Dr. X. ; age 65 years ; practicing medicine in Philadelphia for many years, reported to me for the first time April 15th, 1910.

*History.*—Patient claims to have led a very busy life with no bad habits other than that of tobacco which he both chews and smokes moderately. He complains of a dry tickling cough and shortness of breath. The cough at times is so troublesome that he fears he might choke to death. He has had this condition quite pronounced for fifteen months or longer. He has tried various homœopathic remedies, including kali bich. and phosphorus without results. He has been treated off and on by some of our very able specialists. Furthermore, he claims that he can lie on either side and breathe fairly good but when he attempts to lie on his back his cough begins. He suffers from occasional hoarseness which clears up somewhat after coughing. (He was slightly hoarse at the time of his visit.) He complains of being bothered with some mucous in the post nasal space.

On his second visit a few days later I obtained the further history as follows: The right eye has squinted more or less for the last ten years, but more since three years ago when he had an attack of right sided facial palsy. During these last three years he has suffered off and on with double vision which, in order to avoid, compels him to close the right eye. The attack of palsy did not effect his vision or his hearing.

Present condition: Nose and throat examined on first visit: Septum deviation with moderate degree of hyperplasia



of the mucous membrane with beginning evidences of secondary atrophy. The tongue was flabby, coated moderately heavy and dark in color. Midway between the tip and base of the tongue the coating for an area about the size of a silver quarter dollar was thicker, more velvety and jet black in color. This area, upon closer inspection, proved to be made up of numerous long (4 to 6 m.m) black hairs. One might possibly think the color was due to tobacco stain. To offset this, however, we know that tobacco juice produces a brown stain, whereas the color of these hairs was as black as India ink. So that we had here the so-called hairy tongue in its typical aspect. The fauces presented a very dark, almost purplish, red color with the outlines of the pillars rounded instead of sharp. The uvula was somewhat swollen and it, together with the pharynx, presented the same purplish red color, and all was quite dry. The veins on the base of the tongue were engorged. He was quite sensitive to the use of instruments, but in spite of this fact I obtained a very good view of the larynx and the region thereabout which presented the same general characteristics as elsewhere, namely, slight swelling of the mucous membrane. Dark red or purplish red color, dryness and over-sensibility. I spent considerable time in examining him to verify my findings and before we were through he was seized with an attack of spasm of the glottis. This, when over, prompted him to tell me that he not infrequently had attacks of so-called laryngismus stridulus. My findings led me to ask if he had had his urine examined recently. To this question he answered yes, and stated that it contained sugar. On his second visit he spoke of his eyes and asked me to look at them which I hesitated to do on the first visit, fearing that I might be interfering with the work of his regular oculist. After giving me the second part of his history I proceeded with my examination further.

*Eye.*—Paresis of the external rectus of right eye causing a moderate degree of convergent strabismus, otherwise exterior of both eyes normal. Pupils normal size and equal, reacting promptly to light and accommodation. Ophthalmoscopic examination revealed the presence of multiple retinal hemorrhages both old and recent and in both eyes. I may add that these hemorrhages were so favorably located as not to interfere with his central vision. This led me to take his blood pressure, which I found to be 135-125, but very slightly above

normal and insufficient to cause the retinal hemorrhages. Without any special study for a remedy lachesis appealed to me so strongly that I told him to take it, intending to study up a remedy later. The improvement was so marked that I did not change to anything else. He reported regularly to me at my office for several months and after that only verbally when I would run across him at medical society meetings. His report was always the same. "I'm cured; have no trouble at all," and this he said with a grateful intonation in his voice.

There were many remarkable things about this cure. So remarkable, in fact, that I almost hesitate to tell them. Among the earlier things to disappear were the retinal hemorrhages. After two weeks I could not find a hemorrhage nor could I trace where they had been. The hairy tongue was so typical that I had gotten his permission to show it at one of our medical society meetings, but before the time arrived it was gone. The black color disappeared before the actual hairs and after three weeks they had disappeared too. In this connection we must not forget that the hairs which are due to a hyperkeratosis of the filiform papillæ not infrequently disappear spontaneously. While this transition was taking place his wife remarked that she had noticed him having fewer coughing spells and less choking than formerly. To this he concurred. After six weeks the more pronounced coughing practically ceased so that all that was left was a very occasional hemming. By this time his pharyngeal mucous membrane had assumed a quite natural color.

The most remarkable thing about this case is that his urine ceased to contain sugar, according to the statements of Doctor Roman, who had been making weekly examinations of his urine. I learned of this fact accidentally while in social conference with Doctor Roman. Prior to this time Doctor Roman and I had not had any consultation about the case, and, in fact, I did not know until then that Doctor Roman was the one who had found the sugar originally.

The patient died suddenly a few months ago. I know none of the details concerning his death or whether a post was made. If you desire any of these details I venture Doctor Roman would gladly furnish them.

In this report I am dealing only with the facts that I know. The last time I saw the patient was a few days before his

death, when he gave me his usual report. I regret that he is not living to give us his own report of the case.

Concerning the potency of the lachesis and the frequency of the dose I know nothing. I merely told him to take lachesis and left it entirely to him. He told me later that he was taking it, but I did not think to inquire of him the potency or frequency of the dose.

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### HOMŒOPATHY.

BY

B. F. BOOKS, M. D., ALTOONA, PA.

(Read before the Blair County Homoeopathic Medical Society.)

THE life and welfare of a cause is dependent upon the interest shown therein. Not that interest actuated by selfish motives and confined to those who associate with a cause for the sole object of mercenary gain, but that interest which demonstrates itself by enthusiastic and harmonious activity.

In the past it has been my misfortune to have been misunderstood by some. If any of you have been derelict in your duties to homœopathy and I should say anything which smites your conscience, do not jump to the conclusion that I do so with a feeling of unkindness to you. Accept in the same spirit in which it is meant, for the sake of the advancement of the cause with which we are affiliated. Unity of thought and action in a cause is most essential, and it is only by speaking plainly among ourselves that we can stimulate those who are weak in their faith in homœopathy, to realize their position and create within them the determination to be more true to its principles.

You will pardon me if I digress a moment to speak of the indifference displayed by some of the members of this Society. Various excuses have been offered for this indifference, such as, "too busy," or "I cannot write a paper." More flimsy excuses could scarcely be offered. To the "too busy" doctor I would say that we know you have had time to devote to other matters outside of your professional work. You know that we have been just as busy as you and yet have found time to devote an afternoon or an evening to the cause of homœopa-



thy. You owe it to your fellow-members and to the art by which you earn your living to do the same. To the doctor "who cannot write a paper," I want to say that it is not because of lack of ability but the lack of confidence. Any physician can take up a subject and state his experiences. By so doing he fulfills his obligations as a member of this Society and adds his interest and his presence to increase its influence.

You all know the object of this Society, which was organized about sixteen years ago as the Central Pennsylvania Homœopathic Medical Society. Although the name has been changed its principles remain the same, which are, to more thoroughly disseminate the knowledge of the principles of homœopathy and to work together as a unit in advancing its influence. What have you accomplished in this direction? I dare say nothing. If anything, you have gone back; you have been so indifferent to the advancement of homœopathy, that you have bordered upon disorganization several times and to such an extent that you have been the laughing stock of the physicians of the dominant school. I attribute this largely to the desire for dollars and cents, which has caused you to lose sight of the importance of the principles to which you are pledged. Is it not high time that we should realize this fact; lay aside business for a few hours and join with our fellow-practitioners in a discussion of the principles of true homœopathy, and of the means that can be employed for its advancement? Such a display of interest would bring the wayward into line and we would become a unit in thought and action, as well as in strength.

Homœopathy is familiarly known to you as the law of Similia; but here I fear many of you stop. Many a physician upon whom has been conferred the degree of Doctor of Homœopathic Medicine fails to appreciate the simple, yet far-reaching forces upon which the practice of homœopathy is based. Homœopathy is art; art is nature; nature is God's creation; God's creations are governed by immutable laws. These laws are nature's laws and Similia is one of these immutable laws.

The history of medicine shows us that the principles of therapeutics are based upon pathology. One of the writers of medical history makes the statement that Hippocrates and Paracelsus anticipated the law of Similia. On perusing their writings, however, we fail to find this statement verified. Hippocrates, who has been termed the father of medicine, was

born in the year 460 B. C. He was known in his time as a man of the highest integrity and of the purest morality. Born of a family of priest-physicians, he inherited all of the traditions and prejudices of the age. History attributes to him the elevation of medicine above the mysticism of religion and the vulgar pretensions of the mercenary practitioners of that age. He based his principles of medical practice upon the theory of the existence of a spiritual restoring essence. To aid the influence of this he claimed was the work of the physician, and he stated that it could only be learned by experience. He employed powerful medicines and blood-letting; his remedies were few and many of them were chemical substances. He gave no credence to the idea of definite laws governing the remedies of which he made use. It is evident that the true art of medicine was unknown to him, as such art does not require experimentation. His integrity was shown in his acknowledgment of his inability to cope with many ills. He frequently refused to administer any treatment, stating that nature was sufficient for the cure of disease. With all of this he lacked the knowledge of the existence of the immutable laws of nature, and we find no reason for attributing to him the anticipation of the laws of Similia.

Paracelsus, a physician of the sixteenth century, honest in his convictions and fearless in his expressions, at an early age questioned the value of the teachings of the medical profession. The dogmatic principles of the profession were extremely distasteful to the fiery spirit of this youth, who was eager to make use of what he knew and what he could learn, at once. He strongly advocated the importance of nature in the cure of disease. In the search of curative agents he investigated the value of various minerals. He despised and trampled upon all of the traditions and authoritative teachings of known medicine and advanced a dogma of his own. This was a mystical conception based upon the idea that life was a perpetual germinating process controlled by an underlying spirit and that disease was not natural but spiritual; that nature was sufficient for the cure of most diseases and that Art had only to interfere when the healing processes were incapable of bringing about a cure. Then some remedy had to be introduced that would be antagonistic, not to the disease in a physical sense, but to the spiritual cause of the disease. These remedies were all specifics and he supposed a mysterious con-

nection to exist between the remedy and the disease. Here, we find a man of great intelligence recognizing the power of nature yet utterly devoid of any idea of the immutability of the laws governing the medicinal agents which he employed. The fact that he recognized the power of nature in curing disease and the importance of resorting to the elements of nature's laboratory for remedial agents, is no reason for attributing to him the fact that he anticipated the law of Similia.

As nature, in the common use of the term, refers to essence unchanged by man, the law of Similia surely prevailed from the time of the creation, but, for some unknown reason was hidden from the knowledge of man until the time of Hahnemann.

Hahnemann, it is true, was the founder of homœopathy, but he was not the creator of the laws upon which homœopathy was founded. It appears to me that Hahnemann was created as an agent between the Creator and his creatures and was inspired with the truth of the existence of the laws governing the relation between disease and curative agents. It is evident to me that he became inspired with this truth after he began the study of medicine, as he was soon disgusted with the contradictory teachings that then existed. He found everything in medicine obscure and hypothetical and was tempted to abandon the further study of medicine. However, his desire to search out the truth spurred him on and he at last discovered the law of Similia. He revealed the existence of this law to a few of his intimate associates and solicited their co-operation in further researches. His teachings were directly antagonistic to every medical theory and a large number of his contemporaries were amazed and dumbfounded. In fact they concluded that Hahnemann had lost his reason and all the insults that mind and tongue could invent were hurled at him. Those of you who are familiar with the history of Hahnemann know something of the hardships and of the persecution that he endured. These persecutions, however, only fortified his convictions of the truth of the principles that he had discovered, and struggling on, he finally gave to his fellow-men a system of medicine, founded upon natural law, which was destined to revolutionize the medical world.

It is necessary to realize that the first essential to the successful application of a system of medicine is that it must be based upon an unchangeable natural law. Homœopathy is



founded upon such laws and you can neither take from them nor add to them. The next important essential is a thorough understanding of the laws governing homœopathy.

To those who are doubtful of the value of homœopathy I would say study and test its principles. Select a healthy human subject, perhaps yourself, and administer a medicinal agent until symptoms are produced. Note the symptoms carefully and when you are called upon to treat a sick person suffering from the same symptoms, administer this remedy in a potentized form and, if your judgment is not at fault in selecting the potency, you will be surprised to see the symptoms of the disease disappear. This is a verification of the law of Similia. You who have practiced homœopathy have, no doubt, observed an aggravation of the symptoms after the administration of the remedy. This is known as a physiological aggravation. Under such conditions one should not administer an antidote but the same remedy in a higher potency.

The great Apostle said, "Prove all things and hold fast to that which is good." If you do this you will be a good homœopath. This means study and effort. Unfortunately many students on completing their medical courses consider themselves proficient and make no further effort to familiarize themselves with the principles of homœopathy. I wish to impress upon you that the successful application of homœopathy cannot be acquired by the indolent or the indifferent, but only by persistent and competent study. The results that homœopathy has achieved in medical practice have been revolutionizing. What medical treatise of to-day recommends wholesale bleeding in the treatment of inflammation? Where are the physicians who mercurialized their patients until the treatment was worse than the disease? What has changed the entire system of medical practice and delivered humanity from the danger of excessive drugging? To one and all of these questions we answer, "Homœopathy." Homœopathy has proven to be more than a passing phase in the history of medicine. It has demonstrated its power because it is based upon scientific laws and has opened up to the therapist an inexhaustible field of investigation. It is only the ignorant and the indolent who doubt the value of homœopathy: the ignorant because they are too prejudiced to avail themselves of the opportunity of investigating the truths of homœopathy and the indolent because they find it requires more time, study and effort than they are willing to give to it.

**CYSTO-SARCOMA OF THE OVARY WITH RUPTURE.**

BY

C. WINFIELD PERKINS, M. D., PRINCETON, N. J.

My reason in making this case the subject of a paper, is, the unusual and interesting character of the patient involved, especially so when the age is taken into consideration, and because it is a condition rarely met with in abdominal surgery.

H. W., a bright little girl of eight summers, had an apparent history of good health until four days prior to the operation, when she was taken ill with severe cramps in the abdomen of an intermittent character. This condition was followed by nausea and vomiting of a dark, bilious nature accompanied by great distress in the rectum, and inability to move the bowels either by enema or catharsis. The patient was seen by Doctor Whetmore, of Morrisville, and after careful conservative treatment, the case was diagnosed as possible bowel obstruction, due to some unforeseen cause, and he immediately transferred her to the McKinley Hospital at Trenton on November 23rd, at 12.30 A. M.

On her arrival at the hospital she was given a careful examination by both Doctor McCullough and myself, and after examining her thoroughly the following symptoms were elicited: Pale, anxious face, pulse 128, temperature 100, respirations 28, heart action regular, but weak and thready. Upon examination of the lungs we found the respiratory action was good but accelerated; the lungs were perfectly clear. The abdomen presented a most interesting appearance; it was tense and rotund with distended walls and upon manual examination, elicited marked dullness and fluctuation. The abdominal veins were found to be prominent, associated with a protruded umbilicus; all the above symptoms being conclusive evidence of ascitic fluid in the abdomen. The urine was passed frequently, and had a milky appearance. A high enema was ordered, and was immediately returned without result. A diagnosis of probable tubercular peritonitis complicated with bowel obstruction was made. I decided to operate as soon as possible in order to ascertain the cause of this interesting condition.

Between 12.30 and 4.30 P. M. the patient seemed to rest comfortably with the exception of intermittent cramps in the

abdomen associated with crying spells. At 4.30 P. M. she was brought into the operating room and a small incision was made through the skin and rectus muscle in the medium line below the umbilicus. The peritoneum was then picked up and nicked. As soon as the peritoneum was punctured the ascitic fluid spurted out with great force and about two quarts of serous, sanguinous, odorless fluid was gradually removed in order to prevent shock, which so frequently accompanies any sudden withdrawal of ascitic or cystic fluid from the abdominal cavity. After a large quantity of the fluid was removed the incision was enlarged both above and below, as there seemed to be a large, soft mass protruding into the wound. The examination of this mass showed it to be a rather large, rotund, dark blue mass extending over the greater part of the anterior abdominal cavity; this tumor impinged upon the viscera and omentum in such a manner that they were displaced upwards and backwards, and at this juncture they could not be seen. This mass was covered by a thin serous membrane and at one point could be seen evidences of rupture. The tumor was now delivered through the incision and found to be attached to the left broad ligament in the region of the left ovary. The other pelvic organs, tubes, right ovary and uterus were seen to be in their normal infantile condition. A silk ligature was now thrown around the pedicle. The mass removed and the stumps of the pedicle united. A considerable quantity of sanguinous fluid still remained in the abdominal cavity, and some of this was removed with mops. All the abdominal viscera were found to be in a distorted condition having been pressed upward and backward as a result of the ovarian tumor. Hence the mechanical bowel obstruction and ascites. The appendix was incidentally removed.

As the patient was now in a severe shocked condition, it was considered advisable to pour warm normal salt solution into the abdominal cavity. Considerable haste was now used in closing the abdominal wound as the patient was in a condition of collapse, but happily she responded to treatment, and on leaving the operating room, was in a much improved condition.

As soon as the patient came out of the anaesthetic, 1-16 of a grain of morphia was given. I desire here to state, that I find in the majority of operating cases, 1-16 of a grain of morphine seems to be sufficient to relieve pain and prevent severe shock:



it also stimulates the heart action to a mild degree and taking into consideration the fact that the patient's system is always in more or less of a stupefied condition, as the result of an anæsthetic, this quantity of the drug seems to act more effectively and does not have the depressing effect that a larger dose would have on the economy. My experience suggests that the patient always seems to react more rapidly under the influence of the smaller dose.

The next morning the little girl was smiling and happy and has had an uninterrupted convalescence except for some gastric disturbances of a few days' duration.

The following is the result of the excellent pathological examination made of the tumor by Doctor Frederick Hammond, State Pathologist:

*Examination:* November 25, fresh state.

Specimen, a large, irregularly oval shaped, ruptured sac about the size of two fists.

The sac itself, where present, is thin, smooth and membranous; on one side of the mass there has been an extensive rupture and the membraneous covering is missing.

The contents of the sac consist in a mass of grayish, pinkish and reddish, friable, structureless material which exactly resembles a massive blood clot in various stages, some being relatively recent and some older and entirely fibrinous. At one place there is an egg-shaped area about  $2\frac{1}{2}$  inches in extent which on section presents the cystic, honey-combed appearance of cystic ovary. This area is intimately adherent to the rest of the mass and is covered on its external surface by the same sac which covers the rest of the specimen; it is separated from the latter, however, by a fibrinous wall.

From the macroscopic appearance of the specimen together with the clinical history it is only possible to suppose the condition to be a case of cystic ovary with an extensive hemorrhage into the broad ligament. The nature of the tissue itself suggests no definite idea of the real underlying condition whatever and it is doubtful whether the microscope can be of any material assistance.

Sections are taken from the degenerated cystic ovary and from the mass of clot-like material.

#### MICROSCOPIC EXAMINATION.

As was suggested by the gross examination, practically the

entire mass consists histologically simply of blood clot in varying stages of fibrinoid organization and there is nothing whatever in such sections by which to determine the true nature of the condition.

In one place, microscopically characterized by a cystic appearance, there is a small trace of tissue remnant. This consists in a few small patches of cells lying in a loose, areolar-like matrix. These cells are of round or oval shape and are not unlike the cells of ovarian stroma or might even be considered as resembling sarcoma cells.

This is the only definite tissue structure in the entire specimen and in view of such a finding it is obviously impossible to arrive at any conclusion based on histologic evidence. It is possible, however, that originally the condition was sarcoma, which being followed by severe, massive hemorrhage, has largely suffered destruction.

NOTE: In a recent communication Dr. Perkins states the patient died of sarcoma of the omentum, two months after the operation.—*Ed.*

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IODINE TINCTURE, USE OF, IN VARIOUS INFECTIONS IN CHILDREN.—The author reports results obtained with local applications of tincture of iodine in 660 children suffering from various inflammatory affections of the throat, mouth, nose, ear, etc., as follows: Tonsillitis, 400 cases; chronic and sub-acute otitis media, 32; otalgia, 2; pharyngitis, 42; tonsillar diphtheria, 44; nasal diphtheria, 8; nasal and tonsillar diphtheria, 1; stomatitis, 65; thrush, 5; laryngeal croup, 9; laryngitis, 28; scarlet fever, 9; measles, 7; nasal discharge, 6; multiple furunculosis, 2. In many of the throat cases cultures were taken just before and forty-eight hours after the application of iodine. In every case the second culture showed a very small growth of attenuated bacteria or no growth at all, while a profuse growth was obtained from the first culture. Cases of severe sore throat cleared up and healed in two or three days that might have required a week for cure by other methods. The other classes of patients were also much benefitted. Although pronounced burning or pain in the throat is produced by the iodine, it does not last long and the good results justify the use of the remedy. Where a milder application than the tincture is desired for the throat, especially deep down in it, and in the nose, equal parts of glycerin and iodine tincture are satisfactory. The author has used this combination in the treatment of babies only 1 year old with good results. He lays stress on the prophylactic value of applications of tincture of iodine to the throat in acute contagious diseases, early in the attack and during the active stage of the affection, this measure preventing very materially the spread of the contagion to other members of the family or outsiders.—H. M. Sill (*New York Medical Journal*, December 9, 1911.)

**A SUMMARY OF THE WORK AND RESULTS OF THE INSPECTION OF  
THE MEDICAL COLLEGES OF THE STATE OF PENNSYLVANIA**

BY THE BUREAU OF MEDICAL EDUCATION AND LICENSURE, FEB-  
RUARY 13, 14, 15 AND 16, 1912.

THE Bureau of Medical Education and Licensure of the State of Pennsylvania, created by the Act of June 3rd, 1911, which assumed its duties January 1st, 1912, realizing its responsibility in the protection of the people of this state from unqualified medical practitioners as well as its equally important obligations to the medical profession at large in the uplift of the whole tone of professional life and fitness, not only in this state but in the Nation, began on February 13th, 1912, an inspection of all the Medical Colleges of Pennsylvania.

For the purposes of this inspection the Bureau resolved itself into a Committee of the Whole and during the course of the inspection at no time were there less than four members (out of a total of six) present, the average attendance being five members.

A full half day was given to each institution, the minimum amount of time spent in any one being four full hours. This time was occupied in a preliminary discussion with the Dean and various faculty members in a general conference as to the facilities of the institution and its methods of teaching. This was followed by a personal inspection by the Bureau of each and every point as elicited in the preliminary conference. Every building was fully inspected, each laboratory and its contents looked into in detail. A careful understanding of the methods of teaching and the apparatus available, a full explanation of the system of grading, checking up and final testing of the students' work, was obtained not only from the instructors in charge but in some instances also from the students themselves. Groups of students at actual class and laboratory work were frequently seen and the results of their work inspected. Ward work and dispensary work, as utilized for the benefit of the students, the details of their utility, the details of individual instruction, marking and final testing were observed and verified. The museum and libraries, their condi-



tion, usefulness and modernity were noted. The quality of the student work in drawing, modelling, dissecting, conducting experimental investigations, reporting and, last, but not least, the surroundings, ventilation, neatness of the quarters and the general contentedness and industry of the student were noted. Careful notes for permanent record in the files of the Bureau were taken and will be used in future to note improvements in each individual case.

The results of this inspection, which we believe to be the only thorough and efficient one ever made of the medical schools of Pennsylvania, have been most gratifying and it shows a condition of affairs in the state which places Pennsylvania well in the fore in medical education. By this we do not imply that the colleges are as yet perfect or nearly so, but that in the past few years such an advance has been made as to render the end a sure one which can be attained in a comparatively short time by a well-tempered co-operation on the part of the colleges and the Bureau of Medical Education and Licensure. We hope and believe that this inspection, as well as the future annual ones by the Bureau, will be a stimulus to all concerned, and will result in renewed efforts toward an ideal in excellence.

The preliminary requirements for entrance into a medical school in this state have been standardized by the law and are no longer at the option of the colleges. At least a standard high school course of four years is required and no person in the future, will be allowed to enter a medical school who has not fulfilled these requirements. This entire subject is administered by a separate Bureau in the Department of Public Education of the State of Pennsylvania, and applies to Pharmacy and Dentistry, as well as to Medicine.

The Bureau finds that all the medical schools have, in a general way, divided their course of instruction into two parts—the first two years being in the main devoted to laboratory teaching, the last two years to clinical teaching. With few exceptions, the fundamental courses are conducted in separate laboratories under separate professors. Where the head of a laboratory, such as of Anatomy, Histology and Bacteriology, for instance, is the same, the instructors are separate and distinct in each branch and each has his or her own facilities distinct and separate.

The apparatus in these departments is of the most modern

type and sufficient in quantity for each student to have an individual desk and equipment, which is furnished and owned by the college.

The attractive and most important feature of a large number of laboratories, is a small working library in each, composed of from fifteen to twenty-five volumes, well selected and on the especial topic taught in the laboratory. Students are encouraged to use these freely and we constantly saw such use of the books during our progress. This was entirely separate from a general library, well diversified and open to the students. In almost every instance we were informed that from 75 to 80 per cent. of the student body did actually make use of both the laboratory and general libraries, in fact we observed in several instances, the students, between classes, in the general libraries freely making use of the facilities offered.

In the histological, embryological and pathological laboratories, the drawings by students, which were universally and individually required, and which became part of their record, were surprisingly accurate and complete. In one laboratory every student was required to model in clay each bone of the body, producing a perfect facsimile of the actual bone copied in all its detail, many of the results of which would have been worthy of a class of art students. Most surprisingly complete collections of pathological wet specimens, well classified, as well as charts were found. Class rooms ready for the incoming class, engaged in these subjects, with individual charts and models at each desk were common, and instances of such classes actually at work were frequently seen.

In the bacteriological laboratories the preparation of culture media and the growing of cultures by the students were almost universal as were also the mounting and staining of tissues for microscopic work. In one institution the collections of museum wet specimens of the ear and eye and nose and throat, for demonstrating purposes, in addition to the usual models and charts, were so perfect and complete as to defy improvement and, in this same institution, the museum throughout was filled with the most perfect and precise dissections and classification and might well serve for a working model for other institutions. At another school, models of the female pelvic organs in clay and otherwise, incased in and attached to real bony pelvis, used for gynecological demonstrations were unique and worthy of imitation. Throughout

there was found a universal system of grading in which attendance, together with frequent tests, counted largely as to the students' work, and these marks entered into and became parts of the final test at the end of the term. The chemical laboratory at one institution has so developed this system as to leave little room for improvement and the whole equipment and conduct of the instruction is a model which might well be followed by others.

In physiology, the teaching and equipment leave little to be desired in most instances. Classes were found at actual work, observing the mechanism of the tissues and organs of the body, the action of drugs on these functions and recording the tracings with instruments of precision.

Physiological chemistry, pharmacy and clinical medicine were each taught separately and in their own special quarters.

Anatomical laboratories were found supplied with an abundance of material and the results produced by the students most creditable, both as to dissection and operative procedures. At least three of the colleges have modern cold storage plants for the preservation of their material. The anatomical facilities of one institution having a separate building for this purpose is a model for all others to strive for, so perfect is it in its semi-individual dissecting rooms, post-mortem rooms, cold storage plant, class-rooms, and appliances for demonstrations.

The projectoscope is in common use in all the colleges and in some an additional form of this instrument for the purpose of throwing downward on a plate a greatly enlarged picture of fresh cut specimens under the microscope for demonstration to small bodies of students, were found.

The work during the two clinical years was found to be equally well organized. Only a remnant of the old methods of didactic teaching remains and that only supplementary to the actual bed-side work by the student himself, in small classes. The classes were found to be divided for purposes of study into sections of fifteen or less in different colleges. In the main, not more than six men were assigned to a single instructor. The classes enter the wards, one or two men taking charge of a single patient, taking the history, making the physical diagnosis, securing the excretions and secretions and making examinations of them in the clinical laboratories of the hospitals, making records of all findings and suggesting treatment. All these findings are checked up by the assistant in



charge, the details discussed with the whole ward class, not only by the assistant but by the examining student himself. The student follows his patient from day to day, noticing changes, treatment and progress, until discharge or death; in the latter case witnessing the post-mortem if one can be secured. Individual students in this way personally see from ten to twenty-five cases in the wards. The dispensaries are utilized in the same manner, each student being assigned to a term of duty, practically as junior assistant, taking active part in all the work of the dispensary, even to doing minor operations usually performed under these conditions. Each term of such service is from six to ten weeks. In one institution, the students were assigned in turns to accident wards. All of this work is obligatory and the student is checked up on attendance and graded in his work from day to day, and all of which becomes a part of his final mark at his test at the end of his term in each department. This system is largely followed in the medical wards, surgical wards and dispensaries. The institutions are well supplied with separate dispensaries of the main and special branches of medicine.

This system of teaching is under the absolute control of the Faculty for the reason that, with a single exception, the several colleges of this state own and control, absolutely, their own hospitals, a condition which we believe, exists in no other state to the same extent—a condition, moreover, essential for the best results. Most of these hospitals maintain two hundred or more beds and in addition to this the affiliated clinical facilities are extensive both as to insanity and general and contagious diseases. All colleges in Philadelphia have access to the Municipal Hospital as well as to the Philadelphia General Hospital, in all departments.

Obstetrical teaching is nowhere better developed than in the colleges of Pennsylvania. The maternity hospitals owned by at least four of the colleges, supplemented by large dispensary service scattered over Philadelphia, together with the Magee Maternity Hospital of Pittsburg, provide means for the efficient teaching of this important branch of medicine in this state, though the future will, doubtless, witness even greater perfection in the instruction on this subject.

The Bureau was much impressed by the corps of instructors and assistants seen at the colleges. With rare exceptions, bright, clean-cut young men, enthusiastic and showing most

thorough knowledge of their particular work, both by their conversation and the system developed and the results obtained. Another feature noted was their close personal contact and friendly personal mingling with the student body, the constant attention to the student and the constant application of the student to them for information—the absolute lack of formality. This same spirit of good feeling was noticeable between the professor and the student and the day when the professor seemed to the student to be too big a man to approach, is, in this state at least, a nightmare of the past; in its place is a student body, cheerful and industrious and inquisitive, all of which makes for the best results. As a further step in this same direction and as a means of welding the student body more closely together, several of the colleges have established students' clubs in separate buildings, which clubs are under the joint control of the students and the faculty.

With all this advance in medical teaching, encouraging as it is, there is still room for improvement and it is our belief that the future progress can be very greatly stimulated by such an official body as this Bureau, by obtaining at first hand accurate knowledge of the actual facts and after weighing and analyzing them, to co-operate in the proper spirit with the college authorities, not in a spirit of criticism or contention, or oppression, but in one of constant helpfulness, praising the strong, helping and encouraging the weak and urging on the slothful. The universally cordial and open-hearted reception by the deans and professors of the colleges, encourage the Bureau to believe that the fault will lie in itself if it fail to establish such co-operations.

The criticisms the Bureau may have to offer are in large part such as can be corrected only by an ample supply of funds and in this respect it cannot be too emphatically impressed upon the wealthy citizens of the state that the medical profession is doing its full part to put medical education on the highest possible plane to produce results and that these results are not such as benefit the individuals of the medical profession, but, on the contrary, that they really benefit the public directly. It, therefore, behooves the man of wealth who feels a praiseworthy inclination to do his fair share in conferring this benefit, to furnish means wherewith it can be done. There is no college that could not improve its facilities, good as they

are, were the money in sight for new and more extensive buildings and equipments. No college can assume and maintain a position of the first rank without *owning and controlling its own hospitals and clinical facilities*. One of the crying needs is for full-time paid instructors and, although a few of the colleges have the full equipment in this direction (six in number) recommended by the American Medical Association, as well as numerous part-paid and part-time assistants, others have only half that number and one not that many. The maintenance of professorships on this plan is such a drain on the resources of the colleges, that the situation should be relieved by endowments and the community for its own sake cannot furnish these any too soon.

As to the colleges themselves, we believe they are not all using the clinical facilities at hand as fully as may be done; this is not from lack of inclination but possibly from lack of attention due to the fact that they have not as yet reached this point in the process of evolution from the old to the new methods. For instance, in most colleges practical obstetrical work is given students and a certain number of personal deliveries required before the student can graduate, but not in all is this done, and even in the strongest it is not sufficiently developed. That almost all of the colleges have the facilities for doing this or can acquire them, was developed by our inspection and in order to stimulate all the schools to reach a common footing in this respect the Bureau will require, after 1912, that a candidate for licensure shall have actually delivered six obstetrical cases before he will be eligible for examination. In like manner it is fully evident that the surgical material at large is not being sufficiently used for the benefit of the student. Our investigation has demonstrated to the satisfaction of the Bureau that there is more than ample material at hand to every college in the state to furnish each student the opportunity of actually assisting in operations in the operating room and of personally administering anaesthetics (under competent supervision). Consequently a minimum of six cases in each of these two lines will in future be insisted upon by the Bureau of a candidate for licensure. Some of the colleges have of their own initiative begun this system and have already developed it in a measure. The same thing may be said as to autopsies and the witnessing of six of these will in future be included in the requirements of the Bureau.



It has come to the knowledge of the Bureau that an almost universal custom exists among the colleges of this state to grant re-examination, in the same year, to candidates for graduation who may have failed in two or more branches on examination at the end of the course. After several months, supposed to be spent by the candidate in study on the subjects in which he failed to show proficiency, but over which study the college pretends to no control and of which it has no exact knowledge, he is re-examined on them, and if passed, is graduated and recommended for examination by the State Examining Board in December. The Bureau holds that any student who holds himself unqualified, in two major branches, will unquestionably be ill prepared in his other studies and feels that such student should be required to repeat his senior course and be examined in all of the branches to which he was subjected in the previous year. In view of this opinion the Bureau will in the future admit no candidate for examination who has not conformed to this rule.

Consolidation of medical institutions in general has been generally urged and several times has been discussed with reference to schools of this state. As encouraging as is the situation at this time, the Bureau feels convinced that there are too many medical colleges in the state for the best interest of humanity as well as of the Medical profession and that a consolidation, in some directions and an elimination in others, would be the best possible solution.

In the meantime, the Bureau would urge upon the teachers in the various departments of all the colleges, to make a serious and thorough inspection of the methods of teaching and the facilities possessed by similar departments in all of the other colleges of the state. We find that no one college has a monopoly of all the good and believe that each may be materially helped by hints derived from the others. This would take but a small amount of time and would result in much improvement in weak points and would tend to bring all the colleges up to the same level of excellency.

## EDITORIAL

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### SOME MEDICAL ASPECTS OF THE LIFE OF NAPOLEON BONAPARTE.

DR. BONNETTE, in the *Bulletin du Service de Sante Militaire*, has given a sketch of the life of Napoleon from the medical standpoint. Aside from the historic interest attached to this subject, the account gives us an insight into the medical views that were prevalent in the early part of the nineteenth century and also impresses upon us the important lesson that it is possible for a man to accomplish a vast amount of work in spite of serious physical disadvantages. Napoleon is said to have remarked on one occasion, "Impossible" is the adjective of fools," and the story of his life would go a long way toward convincing us of the accuracy of his observation.

The first illness of Napoleon of which we have any exact record, was an attack of the itch contracted at the siege of Toulon (1793). He never fully recovered from this as it left a recurring eczema. About ten years later, he began to suffer with a chronic cough accompanied by difficulty in breathing; he lost flesh and became mentally depressed, so much so that a fatal termination was anticipated. He refused to have any medical advice, but finally consented to an examination by Desgnettes. After the examination Napoleon pronounced him a babbler and his art as an imposture and refused to follow any advice he had given him. His health steadily became worse and he was finally persuaded to allow Corvisart to examine him. This celebrated physician made a diagnosis of "Itch driven inwards, loss of flesh and pulmonary disorders." He assured Napoleon his trouble was not serious but "merely a humor which had been driven inwards and which must be fetched out again." He advised the use of blisters on the chest and as this treatment was followed by rapid improvement Napoleon bestowed substantial benefits upon him.

The post-mortem examination made in 1821 showed numerous tuberculous nodules in the upper lobe of the left lung and a few old tuberculous cavities. The lung was adherent to the chest wall and to the pericardium.

About 1810 Napoleon became stout and his mind somewhat lethargic. He seemed to have difficulty in grasping situations and in forming his resolutions and even at times fell asleep in planning his campaigns. About the same time he became subject to attacks of acute dysuria, and after his death his bladder was found to be contracted and to contain a number of small calculi. In 1819 he suffered from some affection of the liver and an autopsy made at his death in 1821 by Antomarchi, showed a scirrhus cancer of the stomach which was adherent to the left lobe of the liver.

Corvisart's diagnosis of an "itch driven inward producing pulmonary disorders," forcibly recalls to our mind the statements made by Hahnemann as to the danger of producing internal diseases by the suppression of eruptions on the skin and shows us that such views, which are now commonly made sport of by the opponents of homœopathy, were by no means original with Hahnemann but represented the consensus of opinion of the so-called scientific practitioners of that age.

The symptoms presented by Napoleon at the time of Corvisart's examination, as well as the results of the post-mortem examination, prove conclusively that he suffered from pulmonary tuberculosis which had evidently gone on to quite an advanced stage. With such a physical handicap, it would seem almost impossible for Napoleon to accomplish any work that would require severe physical or mental strain; and yet, despite this drawback, he lived to accomplish a work which, in his sphere, has seldom been equalled and never surpassed.

There would seem to be every reason to believe that the mental lethargy and tendency to fall asleep which, associated with painful and difficult urination that developed about 1810, were largely the result of absorption of toxic substances from the urinary tract; and many of the failures of his later life and his ultimate downfall can perhaps be attributed to this condition.

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#### MEDICAL EFFICIENCY.

EFFICIENCY is the key-note of success in the practice of medicine. While all rules have their exceptions, it can be laid down as a fact that in the majority of instances, the efficient doctor, the man who "delivers the goods," is the man who succeeds, while the inefficient doctor fails.



We meet many honest and industrious physicians who complain that some of their confreres who are notorious for their ignorance of medicine but who are adepts in the art of bluffing the gullible public, have large and apparently lucrative practices, while they struggle along and earn but a very moderate income. In the long run, however, there is little occasion for the capable and honest physician to be envious of the practice of those who resort to deceit and charlatanism in their professional work. The observation of Lincoln that "You cannot fool all of the people all the time," usually proves to be true in time, and the man whose practice is founded upon bluff and deception usually finds it falling away from him after a few years have passed. In the long run honesty is the best policy in the practice of medicine, as well as in other spheres of activity, and if the sincere and industrious physician is not earning as large an income as he thinks he should in the community in which he is situated, the most vital question that should concern him is, whether he has attained the maximum of efficiency in his professional work,—in other words, whether he is "delivering the goods" to the full and complete satisfaction of himself and of his patients.

Efficiency in the practice of medicine, in our judgment, depends primarily upon three things:

First, an up-to-date knowledge of the science and art of medicine.

Second, an understanding of how to effectively apply his knowledge of medicine to individuals who are sick.

Third, industrious attention to professional work.

An up-to-date knowledge of the science and art of medicine is the foundation stone upon which all permanent success in the practice of medicine must be built. Such a knowledge is by no means easy to acquire and even after it is attained, constant study and contact with other medical men are necessary in order that a man may keep up-to-date. It necessitates the purchasing of new books from time to time; it necessitates the reading of medical journals; it necessitates attendance upon the meetings of medical societies and it necessitates the visiting of large medical centers from time to time for the purpose of taking post-graduate courses in those departments of medical work in which the physician is engaged. There is probably no better means by which a physician can increase his efficiency as a doctor and receive fresh impulse to do up-to-date and scientific work, than

by taking a post-graduate course in some progressive medical school or hospital. It gets him out of the ruts of routine practice into which we all fall after a time, and broadens his whole view of the scope and aim of professional activity. It is particularly necessary for the physician who is not succeeding as well as he feels he should. It should not be a question with such a man as to whether he can afford to spend the time and money necessary to attend such a course, but whether he can afford not to do so. Fortunately, the expenses attached to pursuing such courses are very small as compared with the results, both professional and financial, that can be obtained from them. Many doctors will deprive themselves of such opportunities and be content with saving a few hundred dollars which they will ultimately, perhaps, invest in a gold mine or turn it over to some individual who promises a large rate of interest, when they could take the same amount of money and invest it in improving their own knowledge and efficiency with much greater safety and with a much larger return than even the most optimistic promoter can dare to promise.

The second factor which makes for efficiency in medical work, namely, an understanding of how to effectively apply a knowledge of medicine to persons who are sick, must be acquired, largely by observation and experience. The most essential thing in this connection is what is ordinarily known as "a knowledge of human nature." Some physicians possess this intuitively to a large degree, while others must attain it by tedious and laborious experience. An understanding of the fundamental principles of psychology is of considerable assistance in giving us an understanding of the workings of the human mind and of the various emotions and motives which influence it. A study of some of the recent works of psycho-therapy, such as the work of Dubois on the "Psychic Treatment of Nervous Disorders," or Munsterberg's work on "Psychotherapy," will be of great assistance to the physician in perfecting himself in this phase of his professional work.

We can state without fear of successful contradiction that the majority of failures among conscientious and intelligent physicians are due to a lack of understanding of how to effectively apply their knowledge of medicine to sick individuals. The doctor must realize that he is not treating a disease but a human being afflicted with disease. He must adopt his methods not merely to meet the pathological condition present, but

to satisfy and put at ease, the mind of the person whom he is treating. This brings him face to face with one of the most intricate and mysterious problems of creation, namely, the problem of the human mind, and his success in the practice of the medical art will depend to a very large degree upon his ability to properly size up the mental attitude of his patient. He must be able to secure the confidence of that patient, to solicit his willing and intelligent co-operation in carrying out the treatment and to inspire him with hope and confidence as to the outcome of the treatment.

The medical schools in the past have been derelict to their students in this matter, and the average medical graduate enters upon his career with but a meagre idea of the problems that confront him in this direction, and how he is to meet them.

Industrious attention to his work is so obviously essential to the physician in attaining efficiency and success that further comments on this fact are unnecessary.

W-O-R-K, it has been well said spells success, and there is no department of human activity in which this statement is more true than in the practice of medicine. It is true that the profession of medicine is crowded; it is true that medical fees, proportionate to the cost of living, are lower than they have ever been in the history of the profession, but it is also true that there is plenty of room for the man who is prepared to "deliver the goods," and the industrious and efficient practitioner of medicine need have no worry as to his ability to obtain full and adequate compensation for good work.

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CHRONIC APPENDICITIS WITH SYMPTOMS RESEMBLING GASTRIC ULCER.—Dr. F. W. Bancroft (*Col. Medicine*, Feb., 1912) concludes: 1. Pyloric spasm accompanying chronic appendicitis may cause all the symptoms of gastric ulcer. Occult blood may be found in the stomach contents and possibly hematemesis may occur. 2. A kink of the terminal portion of the ileum may cause overdistension of the small intestines which in turn may cause a periduodenal inflammation with resulting adhesions around the pylorus, giving symptoms closely resembling duodenal ulcer. 3. In operating for chronic appendicitis, when the appendix does not show sufficient pathological lesion to account for the symptoms, an incision should be made large enough to examine the terminal portion of the ileum.—*International Journal of Surgery*.



## GLEANINGS

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EFFECT OF SALVARSAN ON THE NERVOUS SYSTEM.—By J. Benario, (*Munchener Mediz. Wchschrft.* No. 14, 1911).—The total result of the statistical determinations, on a clinical material of 126 cases, shows that in 88 per cent. of the cases, nervous manifestations appeared within nine months after the injection, involving the second to eighth nerve, exclusively. The symptoms were more frequently unilateral than bilateral; they occurred in part isolated, in part in a great variety of combinations, which appeared together, or in succession, within the first four months after the injection, in 96.6 per cent. of the cases. These data, derived from a fairly extensive material, positively confirm the view of Ehrlich, who asserts that these disturbances of the cranial nerves are not of toxic character, but are syphilitic manifestations, due to isolated spirochætes, left behind in the sterilization of the main mass; the striking clinical phenomena are referable, not to their extent, but to their localization. Furthermore, Ehrlich's opinion is also confirmed that the relapses occur almost exclusively in cases of early secondary syphilis, in the second, sixth, to eighth month, at which time there prevails an enormous scattering of the spirochætes. It results from the reasons enumerated below, that the nervous affection is not of toxic character, but that the clinical symptoms are produced by swelling, due to pathological processes:

1. The long interval between the injection, and the onset of the nervous manifestations.
2. The character of the pathological process itself, which presents the features of an irritative and inflammatory condition, as was shown especially in affections of the *optic nerve*; instead of the atrophic processes noted after other medication with arsenic.
3. The occurrence of the affection almost exclusively during a definite stage of syphilis.
4. The fact that so far it has not been observed to occur in non-syphilitic diseases which were treated with salvarsan.
5. Its amenability to treatment with specifics, more particularly also to a repeated salvarsan injection.
6. The fact of its having occurred predominantly after small doses of this agent (salvarsan).
7. The appearance of precisely the same manifestations, from solitary secondary chancres to the identical nervous lesions, also under Hg treatment, so that the leading factors is not the chemical agent, but the degree of sterilization that has been accomplished.

It is very evident that the administration of salvarsan is equivalent to a very extensive sterilization, only those spirochætes escaping its action which must do so on account of existing anatomico-pathological conditions. In the ear, for example, which is so often the seat of pathological pro-

cesses, periostitic swellings are apt to be present, opposing resistance against the entrance of any remedial agent. The surviving spirochætes furnish the cause of the nervous relapses, which become manifest as clinical symptoms only by virtue of their seat. The increased attention that has been drawn to these nervous relapses, under salvarsan treatment, is perhaps of good augury for the future. By the recognition of their purely syphilitic character, it will now be possible to treat thoroughly, and finally cure those syphilitic patients, in the early stage of the disease, who would perhaps later on have become the victims of the gravest irreparable cerebrospinal complications. The treatment of the nervous lesion itself should be as prompt and radical as possible, for statistical figures show that the results improve with the timeliness of the treatment.—(*The Post-Graduate*).

THE DIETETIC AND GENERAL MANAGEMENT OF TYPHOID FEVER IN CHILDREN.—By Dr. C. G. Kerley. The author observes that there is no ready-made diet in any illness in a child, neither is there one ready-made scheme for the artificial feeding of infants ill with digestive derangements. At the beginning of any illness milk and so-called solid foods are to be discontinued. As a temporary diet the child is given flavored gruels and perhaps one of the dried milk foods, until the nature of the illness is determined. Under this management there is less gas and undigested milk, and consequently the patient has less temperature and is less toxic when the diagnosis is made. The diet with which the author begins is not necessarily continued throughout the illness. Fat in considerable quantity is poorly digested by young typhoid fever patients. Food containing protein should not be given in considerable amounts until we know something of the course of the disease. Milk, scraped beef, and soft boiled eggs are not well borne in young typhoid fever patients and a temporary reduction of protein is not felt by them. Carbohydrates such as the cereals and different sugars are readily cared for when properly prepared and administered. They supply fuel, have no bi-products and do not require immediate elimination from the body. Emaciation is prevented through their action as proteid sparsers. A suggested diet is the following:

6 a. m. Eight ounces of gruel with sugar or a small amount of broth added. Zwieback or dried bread and butter.

8 a. m. A drink of weak tea with sugar or the white of one or two eggs with sugar in orange juice.

10 a. m. Farina, cream of wheat, rice served with butter and sugar, or maple syrup and butter. Drink of tea or kumyss or matzoon, or perhaps a dried milk food, such as malted milk or Nestle's food.

2 p. m. Eight ounces kumyss, matzoon, or skimmed milk diluted with gruel. Zwieback; dried bread with butter if wanted.

4 p. m. Orange egg sherbet or a drink of lemonade or tea and sugar.

6 p. m. Cereal or gruel with sugar and butter or with broth. If skimmed milk has not been given at two o'clock it may be given with the gruel at this time.

10 p. m. Gruel with sugar or broth or with wine.—*American Journal of the Medical Sciences*.

NERVE SYPHILIS FROM THE VIEWPOINT OF A PRACTITIONER.—Dr. William S. Gottheil states that the following considerations will be of assistance to the medical practitioner in coming to a conclusion as to the probability or not of a syphilitic infection in patients having disturbances of the nervous system:

1. The brain affections of early syphilis are most frequent in the first year after infection, and next most frequent in the second year; 50 per cent. of all cases occur in the first three years; it is most commonly a specific endarteritis, and next most often a syphilitic meningitis with specific infiltration of the cranial nerves, gumma being the least frequent.

2. The paralyses of early brain syphilis, with the exception of those of the cranial nerves, are oftenest due to thrombosis from arteritis, hemorrhage or gumma being rarer. In the very earliest stages the effects of treatment may be brilliant; but when fully developed the lesions are not more amenable to treatment than are similar changes due to ordinary arteriosclerosis or atheroma.

3. Lack of type is a marked symptom of early brain syphilis; so that any case presenting an odd mixture of somatic and psychic symptoms, or a bizarre appearance or disappearance of them, is suspicious. Insomnia, somnolence, or alterations of them; pain or anesthesia; painful anesthesia; spasm, paralysis, or both; monoplegia, paraplegia, hemiplegia, crossed paralysis, single or multiple cranial nerve paralysis, give a hodge-podge of symptoms and partial manifestations.

4. Headache is present in 75 per cent. of the cases; its locality is unimportant; it is usually nocturnal, but it may be vesperal, or even markedly diurnal.

5. Sudden attacks of various kinds are common, and their transient appearance is characteristic. Every sort of fit, from the mildest to the most tumultuous, occurs. There may be dizziness, syncope, momentary unconsciousness simulating petit mal, localized numbness or tingling, spasms, or apoplectiform or epileptiform convulsions.

6. Cranial nerve paralyses are frequent and striking phenomena in early brain syphilis, the eye nerves being most frequently affected: the immense majority of ocular paralyses are syphilitic. Atypical changes in the visual field, sudden blindness without changes in the fundus, paresthesiæ or pains in the distribution of the fifth nerve, tinnitus, dizziness, and aural vertigo, with the well known affections of the third nerve, are common signs of the disease.

7. Progression of the disease by fits and starts, as successive vascular twigs are involved, is a common feature of early brain syphilis.

8. A peculiar stupor or partial stupor is frequent, and is a fairly characteristic symptom, especially when occurring in combination with some of the other symptoms mentioned.

9. The spinal cord and the peripheral nerves are much less liable to be affected than the brain in early syphilis.

10. Late syphilis of the nerve structures occurs only exceptionally during the first three years of the disease; it usually appears later, and may not show itself till 20 to 40 years post infectum.

11. It is usually due to gummatous infiltration of the neural and peri-



neural structures, or to the presence of gummatous tumors, or, finally, to the sclerotic end results of chronic syphilitic inflammatory processes.

12. The symptoms are the classical ones of changes due to degenerative changes or pressure of the nerve structures; paralyses, anesthetics, sensory changes, pain, or the signs of tabes or paresis.

13. Only in the very earliest stages, and more especially when the symptoms are due to gummatous infiltration or tumor formation, is late nerve syphilis amenable to treatment. When sclerotic and degenerative changes have occurred the damage done to the nerve structures is usually irreparable.

14. If, in addition to nerve system symptoms having the above features, there is other evidence of syphilis, past or present, the presumption of the leucic nature of the lesion is strengthened, and a most vigorous anti-syphilitic treatment should be instituted.—*Post-Graduate*.

INGUINAL HERNIA IN CHILDHOOD, MANAGEMENT OF.—In infants it is possible to obtain a cure, the author remarks, by maintaining continuous reduction by means of a truss, but after the second year the chances of cure by this method are doubtful. Surgical treatment, however, is then eminently satisfactory. The rule, therefore, should be fairly uniform: (a) in infants apply truss continuously as soon as the hernia is diagnosed; (b) after the second year consider radical operation if the nutritional index is favorable.

Treatment with the truss can be efficient only when the underlying principles are understood and its application is in the hands of a vigilant and careful nurse. The measuring, ordering, fitting, and hygiene should by all means be supervised by the physician himself. From the time the truss is applied there must not be a moment when the hernial opening is without support. The nurse should receive specific instructions in reference to the purpose of the truss, the location of the hernial opening, the proper placing of the pad, etc. The hygiene of the truss is an important consideration, the problem being to prevent excoriations of the skin, which is constantly subjected to pressure and soiled with urine. The best results are obtained by having two trusses. The truss is kept on while the child is being bathed; when it is removed for cleansing the underlying skin, the nurse is instructed to maintain pressure with the fingers over the hernial opening. The skin is then cleansed and sponged with alcohol and witchhazel, dusted with talcum powder, and the clean and dry truss adjusted in place. Should skin excoriation occur, zinc oxide ointment may be applied. After the truss is prescribed, fitted and shaped, and full directions given for the after-care, the physician's supervision is still essential. The child is developing, and the truss must be changed and adjusted to meet the demands of growth.

After the age of 2 years, if the hernia still persists, the truss should be abandoned and a radical cure performed because: 1. The chances of cure steadily diminish up to the age of puberty. 2. Truss pressure causes atrophy of the underlying muscles, thereby diminishing the protection afforded by them and lessening the chances of radical cure. 3. The wearing of a truss interferes with proper exercise and, therefore, with bodily

development. 4. The cures by truss are often apparent, not permanent. 5. Operation removes all disagreeable sequelæ by establishing normal conditions. With the age limitation mentioned, it is the author's experience that the younger the child the more satisfactory the results of operation.—W. F. Campbell (*Medical Record*, January 20, 1912.)

SOME "DON'T'S" IN CARDIAC THERAPEUTICS.—Don't allow a patient with an uncompensated valve lesion to be out of bed.

Don't let a child or young person with chronic valve disease get out of bed until compensation has returned to the heart and circulatory equilibrium has been maintained for at least one month.

Don't keep elderly patients with myocardial degeneration in bed longer than is absolutely necessary to secure adequate compensation.

Don't give children digitalis, unless there is absolute indication for its use.

Don't give digitalis to old people as a routine measure.

Don't give digitalis to a patient with fatty heart or with any form of pronounced chronic myocardial degeneration.

Don't persist in giving digitalis in chronic valvular disease if the symptoms are rendered worse by its use.

Don't start in with digitalis in mitral stenosis.

Don't give digitalis, strophanthus or any other cardiac stimulant unless rest in bed fails to induce a return of compensation.

Don't forget that digitalis, strophanthus, strychnine and caffeine are the most effective heart stimulants, and that nearly everything in the line of heart stimulation can be accomplished by them if they are correctly exhibited.

Don't use nitroglycerin in cardiovascular disease to reduce blood pressure if the kidneys are much sclerosed, but do not fail to use it freely if coronary sclerosis is present.

Don't forget that individual susceptibility to strychnine varies greatly, and that it is not generally safe to begin with a larger dose than one-sixtieth of a grain every four hours; and that the maximum dose in diseases of the heart is generally not more than one-thirtieth of a grain every four hours.

Don't prescribe passive movements as part of the treatment without watching very carefully to see that they are not given too vigorously.

Don't expect to get compensation in a bad case too soon; be satisfied if the patient shows slight improvement immediately; permanent improvement must be slow if it comes at all; and attempts to hurry it unduly may prematurely exhaust the heart.—*Medical Review of Reviews*.

NOTIFICATION OF VENEREAL DISEASES IN NEW YORK.—On February 20th, the Board of Health of New York City adopted the following resolutions:

*Whereas*, the venereal diseases are infectious, communicable and preventable and constitute a serious menace to the public health, thus properly coming under the charge of the public health authorities; and

*Whereas*, it is well established that no administrative control of such diseases is possible without a system of notification and registration, asso-

ciated with provision for the municipal care of patients unable or unwilling to place themselves under proper medical care and to take the precautions necessary to prevent the infection of others; *be it therefore*

*Resolved*, first, that on and after May 1, 1912, the superintendent or other officers in charge of all public institutions such as hospitals, dispensaries, clinics, homes, asylums, charitable and correctional institutions, including all institutions which are supported in whole or in part by voluntary contributions, be required to report promptly the name, sex, age, nationality, race, marital state and address of every patient under observation suffering from syphilis in every stage, chancroid, or gonorrheal infection of every kind (including gonorrheal arthritis), stating the name, character, stage and duration of the infection, the date and source of contraction of the infection, if obtainable; and

Second, that all physicians be requested to furnish similar information concerning private patients under their care, excepting that the name and address of the patient need not be reported;

Third, that all information and all reports, in connection with persons suffering from these diseases, shall be regarded as absolutely confidential, and shall not be accessible by the public nor shall such records be deemed public records;

Fourth, that the Department of Health shall provide facilities for the free bacteriological examination of discharges for the diagnosis of gonorrheal infections, and also provide, without charge, vaccines for the treatment of such infections; and

Fifth, that the Department of Health shall undertake to make, without charge, the Wassermann and the Noguchi tests for the diagnosis of syphilis and examine specimens for spirochætes;

Sixth, that these diagnostic and therapeutic facilities be extended only when the data required for the registration of the case be furnished by the physician treating the patient; and

Seventh, that the department provide and distribute circulars of information in relation to these diseases.

**NASAL ACCESSORY SINUSES, TREATMENT OF ACUTE AND SUBACUTE INFLAMMATION OF.**—Although there are certainly many cases of this kind which upon the first examination present symptoms demanding surgical means for their relief, the author holds that cases of sinus inflammation should be more carefully treated medically than is now the custom, and the integrity of the nasal mucous membrane with its underlying bony structure preserved in so far as the condition present admits.

In the general treatment, rest in a position favorable to drainage of the cavity, provided the ostium can be gotten open, is most essential. A mercurial followed by a saline should preface the treatment, and the diet should be liquid. Administration of acetyl-salicylic acid proved helpful in many of the author's cases, and hexamethylenamine seemed on one or two occasions to reduce suppuration and hasten recovery. Diaphoresis with hot lemonade is recommended after the calomel and saline. Atropine and belladonna are sometimes valuable, but should be resorted to with great care because of the drying effect on the secretion.



Locally, the application by means of cotton swabs of a 2 per cent. cocaine solution, followed by epinephrin, is best at first. This should be followed by the use of antipyrin in 4 per cent. solution to prolong the ischemia. Cocaine should not be placed in the hands of the patient; where the surgeon cannot make the application, the drug should be used in a spray by the nurse or some one of the family rather than the patient. A spray of some suprarenal preparation in an alkaline medium may be safely used every two or three hours.

After thorough contraction of the nasal mucous membrane, the swab should be used to clear the opening of the sinus or sinuses involved, and the nose irrigated with warm normal saline solution containing a little sodium bicarbonate, taking great care not to force any fluid into the Eustachian tube. After this, a spray of menthol and camphor in an oily medium is of benefit. Mild suction by means of an exhaust bulb or the Brawley apparatus proved beneficial in emptying the sinuses and inducing a favorable local hyperemia. The use of the leucodescent lamp over the sinus was found to give comfort. Hot applications favored reduction of inflammation and hastened resolution, but cold or ice-bags in this region the author considers contraindicated.

Irrigation of the sinuses is a difficult procedure, and in many cases quite impossible without removal of some portion of the middle turbinate bone. To make sure that the tip of the cannula has entered the cavity, an X-ray plate should be made with it in situ. After the irrigation, either with normal saline or some mild alkaline solution, air should be blown into the cavity to dry it and free it from the irrigating fluid. Should such treatment not relieve the condition within a few days, surgery must be resorted to.

In subacute inflammations the treatment is much the same, except that in this class of cases the use of auto-vaccines is of the highest importance. Vaccine therapy is also useful in hastening recovery of acute cases, though the length of time necessary to prepare the vaccines (four days) makes it of little value at the time of greatest intensity of the symptoms. Where improvement does not follow the first injection of vaccine, repeated cultures should be made in the hope of finding the organism truly responsible for the condition. Injections are to be given every five days, though the interval may have to be prolonged a day in order to inject on the rise of the opsonic index.—C. M. Miller (*Old Dominion Journal of Medicine and Surgery*, November, 1911.)

THE TREATMENT OF TUBERCULOUS ADENITIS.—By Dr. John B. Hawes, (*Boston Medical and Surgical Journal*, January 18, 1912,) gives a very careful and complete resume of the management of this important condition. A complete synopsis of the paper is as follows:

The author emphasizes the following points:

1. In tuberculous adenitis we are dealing with an infection with the tubercle bacillus; to combat this it is necessary not only to treat the local process in the patient, but, of far greater importance, to treat the patient himself.

2. To get good results, the portals of entry for the infecting organism

must be closed, and all sources of infection or irritation removed. In other words there must be careful attention paid to the teeth, tonsils and adenoids.

3. The so-called "radical operation" is comparatively rarely indicated; in many cases no surgery is called for; when surgical interference is necessary, it should be regarded merely as a step in a course of treatment the most important part of which comes before and after the operation.

4. The broad-minded physician will not claim that surgery alone, hygiene alone, or tuberculin alone, will cure tuberculous adenitis, but he will use each and all of these three methods of treatment according to the needs of the individual patient. Above all, he will remember that he is not only treating a case of tuberculous glands, but is dealing with a human being infected with tuberculosis. The difference between the two points of view is enormous, and success will largely depend upon the one chosen by the physician.

With a few exceptions one finds in the surgical text-books comparatively little on the subject of tuberculous adenitis, except the details of operative procedure. A few emphasize the need of general hygienic treatment, and still fewer refer to tuberculin as an agent of more or less value. Elsewhere in the recent literature there is a great diversity of opinion.

In regard to the diagnosis of tuberculous adenitis, Allen believes that 60 per cent. of enlarged glands in children are tuberculous; Philip is of the opinion that enlarged cervical glands should be considered tuberculous unless there is definite indication to the contrary, and Freeman, in his article on surgical tuberculosis in Kleb's recent work states that "any chronic glandular enlargement in a child should be looked on as being tuberculous, unless it can be demonstrated to be from some other cause." It is my custom to consider these enlarged glands as tuberculous, if, on careful examination of the patient and treatment of all possible sources of other infection, no other cause can be found.

The tuberculin clinic of the Massachusetts General Hospital is held once a week at 9 a. m., Tuesday mornings. As the patients arrive the nurse takes the temperature, pulse and weight of each on the history card. I then see each patient, go over the record of the past week, examine temperature and pulse record, question carefully as to whether there has been any tuberculin reaction, local or general, and decide as to the next dose of tuberculin. Frequent consultations are held with the surgeons as to the needs of this or that patient.

New patients are immediately referred to both the dental and throat departments unless this has already been done. This is routine procedure in every case. In addition, each new patient is sent to the social service department of the hospital, where the social and financial status is investigated, and, of greater importance, a visit made to the patient's home and a report made on home and family conditions, with special reference to the patient's ability to carry out the details of treatment. At these weekly meetings, men, women and children of all ages meet together. Most of them I know personally, and many I call by their first names. To each individually, and to the group as a whole, I explain exactly why certain things are demanded, why pulse and temperature should be taken regularly,

and why tuberculin is given. There is an average attendance of about twenty to twenty-five patients; this, however, is constantly on the increase. Patients come once a week until this is no longer necessary; they then come once every two or three weeks and later once in one or two months, simply to report.

*Diet.*—Those patients who are at all under weight are instructed to take one quart of milk a day in addition to three good meals. Occasionally olive oil in tablespoonful doses after meals is advised. If the patient is up to normal weight no extra diet is ordered.

*Fresh Air and Outdoor Sleeping.*—In every instance, patients are urged to sleep outdoors if possible; in many instances this cannot be done, especially in the winter; during the summer, and for at least eight months in the year, however, it is surprising how many patients of all ages are willing to do this, if the matter is put to them squarely and frankly. If they do not sleep outdoors, a bedroom with two or three windows is required.

*Rest and Work.*—Whether a patient is allowed to continue at his work or not depends, first, on his general condition, and, next, to the willingness or ability of the patient to stop working. With children it is a comparatively easy matter to settle, with adults, however, especially those who are dependent on what they earn for a living, it is often quite impossible to persuade them that it is safer and cheaper in the long run to give up work for a few months at once. Fortunately, in many cases it is unnecessary for them to do this, especially if outdoor sleeping can be arranged for. Each patient presents a problem in this regard which must be decided independently of all others.

*Tuberculin.*—Tuberculin is given according to the well-known rules laid down by Trudeau. I use a bouillon filtrate kindly supplied from the Saranac Laboratory; its administration has been carried on under Dr. Trudeau's directions and supervision. The initial dose is very small 1-10,000 to 5-10,000 mgm.; this is gradually increased up to 5 to 10 mgm. In rare instances I continue injections up to 15 to 20 mgm. Reactions are avoided whenever possible. It is not always possible to avoid a local reaction in the arm, but a careful watch for this and other minor signs of intolerance should always enable the physician to avoid any but the mildest of general reactions. In the majority of instances, whenever the intelligence of the patient admits of it, careful record is kept of the temperature and pulse taken at 8 a. m., 12 m., 4 p. m., and 8 p. m. When the patient cannot do this, I depend on the clinical signs and symptoms as guides for dosage.

*Surgery.*—Surgery is made a consideration secondary to the general treatment of the patient. Patients with broken-down glands, discharging sinuses, etc., are sent to the surgical department for proper dressings; glands which break down and become fluctuant are sent to the surgeon to be incised and evacuated. In a few instances when, after a prolonged and thorough treatment with hygiene and tuberculin, enlarged glands still remain, while the general condition of the patient has been raised to the highest possible point, excision is advised. The present tendency of the surgeons of the Massachusetts General Hospital at least is to send patients to this department for general treatment and hygiene at once, and, except



in cases of actively suppurating glands, not to consider surgical interference until later.

*Lung Examinations.*—The lungs of every patient are examined on admission to the clinic, and in every suspicious case monthly examinations are made. During the past five years six of these patients have been found to have pulmonary tuberculosis, and have been sent to sanatoria for treatment.

1. *Summary and Conclusion.*—To get good results in the treatment of tuberculous adenitis the author believes it to be more important to treat the patient than to devote one's attention solely to the tuberculous process in the glands.

2. The physician should not depend upon surgery alone, hygiene alone or tuberculin alone, but should use all or each of these measures as is required by the individual patient.

3. Out of this series of 56 patients, treated according to the methods here described, in 27 the disease has been apparently cured or arrested, while in 16 others the condition of the patient has been improved, while the number of cases in which there was no improvement after a fair trial was very small indeed.

4. The author believes it to be essential to success that patients should be treated in a special department, such as the one here described, entirely distinct from the other departments of the hospital and yet working in the closest co-operation with them. It is my opinion that every large dispensary or out-patient department should have a special clinic for the treatment of this class of tuberculosis patients.—*Post-Graduate*.

CONTRIBUTION TO THE QUESTION OF THE EFFECT OF SALVARSAN ON LUETIC OCULAR AFFECTIONS.—The author treated 12 cases (9 acute, 3 quiescent) of interstitial keratitis with intravenous and subcutaneous injections of salvarsan. In only two of the acute case was no satisfactory result obtained. In one of them the other eye, too, became affected; in both, however, the disease ran a mild course.

No result was obtained or expected in the three quiescent cases where salvarsan was used as a prophylactic. Six cases of iritis (2 acute, 2 relapsing, 1 chronic with plus tension, 1 non-luetic, but with a luetic history) were also subjected to the treatment. In only the acute cases was a favorable result obtained.

In two cases of palsy of the ocular muscles no cure was effected. In a case of bilateral choked disk of doubtful etiology and one of old chorioiditis the only improvement noted was in the general condition.—Dr. E. Seidel, Heideberg, *Graef's Archiv. fuer Ophthal.*

WILLIAM SPENCER, M. D.

OCULOMOTOR PARALYSIS AFTER THE INJECTION OF "606."—The case was that of a boy of 18 who received an injection of 0.45 c. gr. of salvarsan in the inter scapular region from a tube coming from Ehrlich himself. The chancre had been in existence three weeks at the time of the injection, and inguinal adenitis and roseola had already appeared. In four days the initial lesion and the exanthema had disappeared, the glandular swell-

ing was gone at the end of a month, and the general condition of the patient was highly satisfactory. The eyes had been examined prior to the injection and found normal. Eight weeks after the injection the patient began to suffer with headaches, which were more severe at night. A week later complete ptosis of the left lid, followed in four days by paralysis of all the muscles supplied by the left common oculo-motor nerve. Potassium iodide had no effect on the condition; potassium bromide eased the headache, but was also ineffectual as regards the paralysis. Six weeks later there was total ophthalmoplegia, a static refraction of  $\pm 2.00$ , normal fundus, vision  $= 1/2$ . The right eye is emmetropic, and its vision  $= 1.00$ . Backward pressure on the left globe causes pain. A month's treatment with mercurials had no effect aside from increasing the range of accommodation slightly and causing the subsidence of a swelling of a retro-auricular gland. Although the serodiagnosis showed the presence of active syphilis, Trautas did not dare risk another injection of "606," believing the paralysis the result of the first injection. Oculo-motor paralysis is extremely rare during the first months of syphilis; when precocious optic neuritis is found there is generally some good reason to account for it, such as alcoholism, senility, or some dyscrasia. M. Stern found 3 cases of paralysis of the ocular muscles amongst 5,000 syphilitics; whereas 200 syphilitics treated with salvarsan furnished 3 cases. Finger found 20 cases amongst 170 patients treated with salvarsan. These paralytic cases appear 2 to 3 months after the injection with sufficient regularity to suggest a casual connection.—Trautas, *La Clinique Ophthalmologique*.

WILLIAM SPENCER, M. D.

PARENCHYMATOUS KERATITIS TREATED WITH SALVARSAN.—The author tries to say a good word for salvarsan in the treatment of the keratitis of congenital syphilis, but his article is not very convincing, and he does not seem to have accomplished any more than the other investigators. Like others he finds that salvarsan will, in acute and vascular cases, stop the blepharospasm, photophobia and over-vascularization quicker than any other remedy. The improvement in vision was so slight in many cases that it might easily have been the result of the other remedies employed. The clearing of the cornea took place mostly at the periphery, the changes in the important pupillary area being slight. In one case, however, the vision improved from R. 0.50 ct m., L. 2.00 to R. 6-20, L. 6-10, inside of a month after two injections of salvarsan. He finds it more advantageous to give several small doses of salvarsan than one large one.—Wicherkiewicz, *La Clinique Ophthalmologique*.

WILLIAM SPENCER, M. D.

EHRlich-HATA 606 IN OPHTHALMOLOGY.—A review is given of the methods of using 606, with the results of various authorities, and especially what has been done in the domain of ophthalmology. He attributes the small percentage of ophthalmic cases to be due to caution on account of some of the horrible results of the arsenical compounds, especially atoxyl. Among the cases which he has collected up to date on which 606 has been used are the following:

1. Four cases by Neisser. (a) Brain lues, six months after infection, with choked disk, eye muscle paralyses and severe headaches; which was relieved completely and rapidly of all symptoms after injection of 0.2 of 606, when K. I. and Hg. had had no effect. (b) Three cases of interstitial keratitis without results.

2. Six cases by Wechselmann. (a) Optic neuritis, which had resisted the influence of Hg., rapidly cured with 606, with normal vision restored. (b) Five other cases with abnormal optic nerve without 606 producing any harmful results.

3. Two cases by Treupel. (a) Syphilitic kerato-iritis with positive Wassermann; cured eight weeks after injection of 606. Three months later returned, with slow healing after a second injection. (b) Paralysis of the left side, with ptosis and paresis of left internal and external recti following apoplectic attack. Showed rapid improvement after injection of 0.3 of 606 with slight paresis of recti and slight ptosis remaining.

4. Four cases by Gluck. (a) Interstitial keratitis which had been under treatment for one year with Hg., showed rapid clearing immediately, but three weeks later were still hazy. (b) Very severe iritis with synechia, photophobia disappeared two days after injection of 0.4 of 606, with complete cure in four days, with the exception of the synechia, which had disappeared eight days later under atropin. (c) Double iritis cured three weeks after injection. (d) Optic atrophy. No result.

5. Dorr. One case of diplopia cured in three weeks.

6. Two cases of Hoffman. (a) Exophthalmos and abducens paralysis in hereditary syphilis rapidly cured after injection of 606. (b) Tertiary iridocyclitis and hyalitis. No results given after the treatment.

7. One case of Igersheimer. Interstitial keratitis, negative results.

8. Ehrlich. Excellent results in retinitis syphilitica and iritisgummosa.

9. Axenfeld. Rapid recovery in a case of irisgumma. He deprecated the fact that ophthalmologists have not been given 606 for a special trial in eye cases, and also that the preparation is not yet on the market. He states that Ehrlich is still working to improve the preparation and has already discovered "Hyperidial," which is called Hy. for short. Its poisonous effect is said to be one-third that of 606.—Dr. Stucep, *Annals of Ophthalmol.*

WILLIAM SPENCER, M. D.

THE ACTION OF SALVARSAN UPON THE EYES.—The grave accidents which have been observed following the use of certain arsenical preparations in the treatment of syphilis made syphilographers circumspect as to "606." Several cases of optic atrophy and other ocular lesions have been published as following intravenous injections of salvarsan. Most of the reported cases show oculo-motor and optic nerve involvement. The symptoms not appearing for several weeks after the injection. All the paralysis have been mild and generally recovered after repeated injections of salvarsan, or iodine or mercurial treatment. There does not seem to be any atrophy of the nerve or blindness following. Jeanselme and Coutela have observed papillo-retinitis during the secondary period after injection of 0.40 gramme arseno-benzol. Antonelli and Courtois-Suffit published a



case of iritis and optic neuritis twenty-four days after an injection. Geronne and Gutmann recite cases when four months after injection the patient developed headache, tinnitus aurium, optic neuritis and heminopsia. Two more injections did not modify the course of the optic neuritis. It is noticeable that, with rare exceptions, these accidents occur during the secondary period. The question is, are these nerve lesions of the optic nerve or motor attributable to the salvarsan or to the syphilis which was not cured by the treatment. Jeanselme and Coutela do not doubt but that the condition is not medicamentous intoxication, but a syphilitic one as a second intravenous injection of "606" results in cures.

Antonelli and Courtois-Suffit believes the lesions syphilitic in origin because they are usually unilateral and accompanied by other accidents that belong to the secondary stage of the disease, while the nervous lesions following the use of arsenical preparations, as atoxyl and arsacetine, are bilateral. According to Geronne and Gutmann all these accidents may be attributed to a meningeal irritation, cerebral or medullary, so frequent in syphilis. They believe that salvarsan without having a true toxic action, may have, nevertheless, a certain neuropathic action which causes some slight alteration in nervous tissue not discernible microscopically. Syphilis thereupon localizes at a point of lowered resistance. This hypothesis seems to be confirmed by actual observations. This leads one to observe precautions before using this drug. The eyes should be carefully examined as to the field of vision, the condition of optic nerve, and the retina and the pupillary reflexes. The question now is, should syphilis cases with ocular lesions be treated with "606?" That these lesions have appeared after the use of the drug does not say that it will not cure them. The fact remains, however, that up to the present the results obtained with mercury have not been surpassed.

The author is led to believe that in oculo-motor and optic nerve lesion "606" is nearly contraindicated. In these cases mercury should be used: however, if mercurial treatment does not produce amelioration of symptoms we should use salvarsan.—Dr. P. Bailliart, *Bull. gen de Therapeut.*

WILLIAM SPENCER, M. D.

GENITAL TUBERCULOSIS IN WOMEN.—Schlimpert has made a study of this subject from over 3,500 post mortem examinations. He found that tubercular peritonitis may arise from intestinal tubercular ulcerations, through the blood and lymph channels, even from distant organs, and from the genitals themselves. It is usually combined with the disease affecting other organs. Genital tuberculosis occurs mostly between the ages of 20 and 30 and between 40 and 50 years. The disease arose mostly through the blood channels, and it usually localizes in the tubes. In all cases where the vagina was affected the disease was localized, probably came from other affected organs, and did not arise from coitus. When affecting the cervix the disease was combined with general tubercular disease. In the uterus it is found associated with tubal tuberculosis, having arisen through the blood vessels. In the tubes the disease usually manifests itself as a pyosalpinx. The disease is rarely seen in the ovaries. In one case a miliary form was seen, in three cases the serosa was involved, and in

other cases the uterus was also affected. Genital tuberculosis usually accompanies the disease existing in other organs. In the urinary tract the origin of the disease is usually hematogenic; it may ascend from the bladder during manipulations of traumatism, and may spread to other organs by continuity. Primary and isolated tuberculosis of the urinary organs does not occur. Its origin is generally hematogenic or descending. It occurs in combination with genital tuberculosis, but differing from the disease in men, it occurs without being dependent upon the same affection in the genitalia.—*Arch. f. Gyn.* Vol. 94, 863.

THEODORE J. GRAMM, M. D.

ALBUMINURIA IN PREGNANCY, LABOR AND THE PUERPERIUM.—Jaeger (Elberfeld) has studied the subject anew and has found that 70% of pregnant women have albumin in the urine. The frequency of its appearance increases in the later months. Prima and multigravidae are equally affected. In 25% the albuminuria was lordotic. Where a bacterial infection of the urinary tract existed a direct injury of the kidneys may result during pregnancy and after labor. Kidney lesions during pregnancy, shown by hyaline granular or epithelial casts, were found in 11%. In lordotic albuminuria there is an absence of casts, but the albuminuria increases during labor, and at the same time casts appear. In the urine passed during labor albumin is only exceptionally absent. The albuminuria during labor increases with the severity of the labor, hence it is more pronounced during first labors. Casts were found during labor in half of the cases and disappear during the puerperium. If it was pronounced during labor it disappears the more slowly during puerperium. As causes for albuminuria in pregnancy and during labor we must regard mechanical, infectious and toxic conditions. In some instances there is present a certain constitutional diminished ability of the secreting tissues of the kidney.—*Zeitscht. f. G. u. G.* Vol. 68, 730.

THEODORE J. GRAMM, M. D.

THE INCORRECT DIAGNOSIS OF RECURRENCE AFTER OPERATIONS FOR CANCER.—Sitzenfrey's contribution gives material encouragement for operating in cancer of the uterus. Neoplastic or irritative conditions after such operations have been too frequently diagnosed as recurrence without warrant. He calls attention to the necessity for microscopic diagnosis of such assumed recurrences, and shows that in two cases after abdominal hysterectomy, the tissues supposed to contain recurrent cancer consisted simply of granulation tissue, and in the second case there was present tubercular disease of the retroperitoneal tissues. These are not isolated instances and other similar experiences are referred to.—*Zeitschr. f. G. u. G.* Vol. 78, 106.

THEODORE J. GRAMM, M. D.

THE VACCINE DIAGNOSIS OF ADNEXAL DISEASES.—Reiter has applied the methods used in the tuberculin reaction in the diagnosis of adnexal diseases, using for the purpose streptococcus, staphylococcus and gonorrhœal vaccines, and believes the method quite promising in cases present-

ing difficulties in differential diagnosis. Omitting all the details of his investigations, he found a positive reaction at the seat of the disease, proof of the specific infection. The local condition was also favorably influenced by the injections, while no bad effects were ever observed.—*Zeitschr. f. G. u. G.* Vol. 68, 471.

THEODORE J. GRAMM, M. D.

BLOOD PRESSURE IN OBSTETRIC CASES.—Jaschke's studies have shown that in the first half of pregnancy there are no particular variations; in the second half there is a tendency for the blood pressure to be increased up to and above the highest limits of the normal, and there is a close relationship to pulse frequency. During labor the blood pressure is characterized by great sudden variations, dependent upon the various stages of the labor. In the puerperium the blood pressure tends to be diminished. There are no particular differences observable in those who get up early from those who remain confined for a longer time.—*Arch. f. Gyn.* Vol. 94, 809.

THEODORE J. GRAMM, M. D.

HIRUDIN IN ECLAMPSIA.—Hirudin, an extract from the leech, is being studied abroad. Its use is based upon the evidence derived from post-mortem findings which indicate with increased certainty that most of the lesions of eclampsia are referable to a coagulating substance circulating in the blood. The intravenous use of hirudin should theoretically prevent and overcome this condition, and it has so done practically. Englemann has treated 14 cases and has observed that there has been a pronounced effect upon the convulsive seizures, in some cases terminating them at once, and in other instances where the seizures recurred the intervals were materially lengthened. The use of this substance is still in the experimental stage, and several men abroad are giving attention to it. One occurrence which on theoretical grounds was feared, has not materialized. It was feared that the injection of a substance diminishing the coagulability of the blood would have as an associated condition the danger of certain post partum hemorrhage. This has not, however, been observed in the cases treated.—*Zeitschr. f. G. u. G.* Vol. 68, 642.

THEODORE J. GRAMM, M. D.

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Homœopathic Medical Society of the State of Pennsylvania,—Annual Meeting for 1912 at Delaware Water Gap, September 17, 18 and 19.

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American Institute of Homœopathy,—Next Meeting at Pittsburgh, Pa., June 16th to 22nd, 1912.



## Monthly Retrospect

### OF HOMOEOPATHIC MATERIA MEDICA AND THERAPEUTICS

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CONDUCTED BY A. LEIGHT MONROE,

Miami, Florida.

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WHAT TO DO FOR THE NERVES.—CATALEPSY.—In the further study of our therapeutics of catalepsy we find some very interesting matter. Our next remedy will be coffee. Here, as in remedies previously mentioned, we have no pathology to guide us in prescribing.

Coffee is unique in this: that it is a great nerve excitant. In catalepsy calling for coffee we have an individual who is highly sensitive, his senses are unusually active. He is wide awake at night, sees and hears more readily than an ordinary individual. Indeed, he is so wide awake that it seems impossible for him to close his eyes. He is ecstatic, full of ideas, constantly building air castles; quick to act, and, because of this hyperactivity of the mind, it is impossible for him to sleep. Apart from this nervous excitability, we have hyper-sensitiveness to external impressions. Now then, having such an individual under severe excitement, followed by an attack of catalepsy, we have our remedy—coffee. One more point, and it is this: Some hyper-sensitive people are often afflicted with severe headaches, and these headaches are likened unto a sensation as of a nail driven into the brain, or as if the brain were torn or dashed to pieces.

Our next study will be that of *conium*. One of the first peculiarities is that it has a tendency to cause rigidity of the muscles, constriction of the fibres, swelling of the glands, and diminution of the senses. Here we find certain pathological conditions, in addition to our nerve disturbances. There is great tendency to vertigo, aggravated when lying down or turning over in bed, especially to the right side. Mentally, conium is lively, quick, of a hopeful disposition, and with this mental activity we find, as time goes on, a marked weakness of the memory. There is also a great deal of numbness, beginning in the feet and extending upwards. With this numbness there is more or less oedema, according to the severity of the trouble. The catalepsy of conium is marked by its tetanic rigidity. The fibres become constricted and indurated.

In the study of *gelsemium* we enter a very interesting realm; it is a realm of nerves. Trembling, paralytic weakness of the limbs, tendency to motor paralysis, muscular paralysis and spasms. Headaches, with this great peculiarity, of being confined largely to the right side, originating in the occiput, extending forward to the sinciput and preceded by blindness. It is full of hysteria, it is excitable, with functional disturbances

of various organs through excitement. Catalepsy, therefore, of gelsemium is very closely associated with hysteria, and by your permission, Mr. Editor, I desire to call this *hysterical catalepsy*. The spasm itself is characterized by motor immobility, dilated pupils, closed eyes, but conscious. The patient knows all that is going on, hears everything that is said, but cannot open her eyes, cannot speak a word and cannot move a muscle. There is no remedy in the materia medica so fruitful of good results in conditions like those above mentioned as is gelsemium. What a strange family of creatures we are! Externally we seem to be much alike; internally we are full of divergencies, some of which seem almost inexplicable.

We enter the field of *hyoscyamus* and we find, when sick, muscular twitchings and jerkings, staring eyes, foolish, nonsensical laughter, a tendency to immodesty, refusing to be clothed or covered with bed clothes, absurd deportment, boisterous, laughing and talking; the very picture of excited though morbid nervousness. Such an individual is full of convulsions, spasms, cramps, epilepsy, chorea and a multiplicity of spasmodic affections. To say that such a one is nervous is putting it mildly; they are really *maniacal*, and, with all this nervousness, it is strange to say, we find the individual sanguine, hopeful. The convulsive state, however, is characterized by marked and violent twitchings of the muscles, beginning with the muscles of the face, especially those of the eyes, and from here the twitching extends through the body. The limbs are drawn up, the body is bent forward, the arms are thrown about, the vital forces sink rapidly, the patient seems to be going down to death, the eyes stare, the lips close spasmodically, the teeth are clenched, the throat is constricted, and our patient is in a pitiable condition. You can accomplish little during a convulsive attack. Loosen the clothing, make them as comfortable as possible, and wait until the attack is over; then study your case carefully. The time to cure these conditions is when there are no convulsions. *Hyoscyamus*, when properly administered, will not only prevent such cataleptic convulsions temporarily, but will cure them.

Our next study will be *ignatia*. Our disposition is to spend a great deal of time in portraying the nerve disturbances of these various remedies, but we hasten to as much brevity as clearness will permit. *Ignatia* is very sensitive to pain; suffers intensely from grief or supposed mental anxiety. There is languor, trembling of the hands and limbs, faintness, false hunger, weakness, exhaustion of the whole body, lassitude in the evening, jerking and twitching of the various muscles, formication, as if a mouse were crawling under the skin, with great tendency to stupor. The convulsions of *ignatia* are predominantly chronic, and are brought about by fright, grief, mental emotion and fear. Now the catalepsy of *ignatia* is characterized by the result of grief or disappointed love.

In *ipecacuanha* our central idea is nausea. Nausea, when recovering from a cataleptic attack, accompanied by great weakness, sudden prostration and aversion to all food, is not to be forgotten. There is also great sensitiveness to heat and cold. The convulsions of *ipecacuanha* are tetanic in their nature, characterized by great rigidity of the body and twitching of the face. These convulsions circulate around and emanate from the

functional disturbances of the digestive organs; thus, anything that disturbs the digestion, producing nausea, not relieved by vomiting, leads you to think of ipecacuanha. Spasms brought on by the inhalation of tobacco smoke or the swallowing of tobacco juice lead you to think of this remedy, and the very peremptory demand to stop the use of tobacco.

In *lachesis* we see the serpentine world with all its poisonous effects. Here we have irritability, restlessness, moaning, trembling of the limbs, thoughts of fainting or falling down from weakness, aches and pains all over the body, cramps in the chest and abdomen, pains in the back of the head and neck, coldness of the feet, aggravations from all pressure, especially that of the clothing, aggravated from sleeping; aversion to company, great depression of spirits, apprehension of death, and many other nerve disturbances. The convulsions of lachesis are associated with the menstrual nisis or menopause. Again, the convulsions of lachesis are likely to predominate in the spring of the year, or the early summer, or from the heat of the sun. The catalepsy of lachesis is characterized by clenched hands; the left hand and foot and the right eye are in constant motion. There is a forcible protrusion and retraction of the tongue, and the face is deeply congested. Before the attack the feet grow cold, violent palpitation of the heart, bloating of the abdomen, eructations, heaviness of the head, vertigo, headaches and paleness of the face. As already indicated, the time to cure these cases is when the patient is free from the attack. The catalepsy of lachesis is reflex and points to other regions that must be remedied.

In *natrum muriaticum* we have emaciation, especially about the neck; loss of flesh while eating well, chlorosis, and a general tendency to anæmia. Weariness and restlessness are characteristic of all the natrums. Not only this, but you will find in a careful study of the natrums that there is a marked vein of sadness and forebodings. In these remedies fear, fear as if something were going to happen, fear that bad news may come, and fear for their own physical condition. The troubles of natrums are usually worse in the morning and in the forenoon. They are full of jerkings and twitchings of the body, trembling of all the limbs, great prostration of the whole body. The catalepsy of *natrum muriaticum* is characterized by various contortions of the body, and, very much like *gelsemium*, the patient is conscious during the attack.

In *platinum* we have not the despondent individual we have in the natrums, but we have the bigoted autocratic individual, who thinks himself better than others and feels as if he were physically larger. The patient is weary, relax and prostrate. There is a great tendency to paralytic weakness. This brings on fear, fear of death, which they think is near at hand. Platinum is full of hysteria, and the predominant characteristic of this hysteria is weakness of the chest, so weak they cannot speak above a whisper, and even a faint whisper seems to exhaust. There is great tremulousness of the whole body, and this tremor is full of pain. Now we have great uneasiness, restlessness, fidgety limbs; they do not know where to put their hands or feet. The catalepsy of platinum is characterized by rigidity of the limbs, spasmodic yawning, loss of speech, distortion of the eyes, involuntary twitching at the corners of the mouth



and eyelids, and with the yawning there is tendency to lockjaw. The jaws sometimes lock when closed, but more frequently when open.

Our next study is brief. It is that of *sabadilla*. *Sabadilla* is full of imagination; imagines he is sick when he is not, imagines that he is swollen when he is not, or imagines that he is all shrunk up when he is not, and in these imaginings they become morose, taciturn and irresponsible. They are full of vertigo; they feel as if everything were turning around in a circle, or as if they were intoxicated. We have great debility, lassitude and bruised pains in various parts of the body. The convulsions of *sabadilla* are full of twitchings and tremblings, and the catalepsy of *sabadilla* is a sequence to intestinal parasites.

*Stramonium* is full of fury, delirium, hallucinations, and loquacity. There is great inclination to lie down, weariness, lassitude and debility. There is uneasiness, restlessness, tendency to fall, especially when walking in the dark. The motor nerves are severely afflicted, and we have, therefore, a tendency to progressive locomotor-ataxia. *Stramonium* is full of hysteria, chorea, spasms and constriction. The catalepsy of *stramonium* is due largely to injury to the head. The patient is quiet, immovable, and, though not rigid, the limbs remain in the position in which they are placed by others, while the patient is unable to move the limbs voluntarily. Before an attack there is vertigo and headache.

In *thuja* we have a great deal of restlessness, exhaustion, and a tendency to hemiplegia. The convulsions of *thuja* are not very characteristic, but we find a syctic constitution, the growth of morbid products, such as warts, tumors, etc., and evil results from vaccination, particularly convulsions from vaccinations in a syctic constitution. This is a remarkable remedy to use in the removal of morbid growths, clearing syctic constitutions and upbuilding depleted nerves.—George E. Dienst, Aurora, Ill., Sept. 13, 1911, (*The Critique*).

BALSAM OF PERU.—By A. E. Hinsdale, M. D., Bay City, Mich.—A fluid composed of castor oil, 95 per cent., and Balsam of Peru, 5 per cent., has great "healing" properties, and may be applied to sores and indolent ulcers and infected wounds. The solution should be sterilized before using. This application has speedily cured infected wounds after failure to get relief from hydrogen peroxide and the other usually used antiseptics.

ACIDUM BENZOICUM IN CHRONIC SYNOVITIS OF THE KNEES.—This drug is generally looked upon as indicated when the synovitis is confined to the right knee only, but cases have been reported to me, in which its results were just as brilliant where the left knee was affected. In these cases two drops of the 2x dilution were administered every four hours.—(*Jan. Century*).

GLONOINE.—Allen says in angina pectoris it is indicated where there is fluttering of the heart and violent beating as if the chest would burst open. Labored breathing, pains radiating in all directions, even into arms with loss of power in the arms. Labored action of the heart, as if it were being contracted; sharp pains; violent palpitation; heart easily excited; pulsating headache; purring noise in heart; must have head high; must rise and walk; pulse intermittent. One tablet saturated with the 4x dilu-

tion, three or four times a day, is a good manner in which to dispense the remedy.—*Hinsdale Century*.

**URTICA URENS IN GRAVEL.**—This remedy is indicated in cases where there is a *red, sandy sediment*, accompanied with much flatulence in the abdomen, and *obstinate constipation*. Five drops of the mother tincture, administered every six hours, taken for two or three weeks, and then once a day for a month, generally effects a cure.—*Hinsdale Century*.

**NUX JUGLANS.**—By A. L. Blackwood, B. S., M. D., Chicago, Ill.—This agent is also known as the *Juglans regia*, the nuts upon which the gods are said to have lived during the "Golden Age." The walnut is important as a food. Its sap produces sugar, and from its fruit there is dye, oil and pickles made. Lumber is made from the trees, while from the leaves and the rind of the green fruit a tincture is prepared and employed in medicine for the relief from disease.

When taken internally there is developed a distension of the abdomen, which is attended with frequent eructations of gas and the discharges of much flatus. The fermentation involves the whole gastro-intestinal tract. There is pain, especially in the region of the splenic flexure of the colon. The appetite is good and there may be extreme hunger. The tongue is coated white and there is a bitter, slimy taste in the mouth upon waking. There is a dull pain in the forehead over the eyes, especially when moving or shaking the head. The stools are soft and copious, and in some cases are nearly liquid in consistency and may be attended by a sensation of burning in the anus. The urine is increased in quantity. There are pains in the extremities that simulate rheumatism. The menstrual period is too early, is prolonged; the flow is profuse, dark and clotted.

The skin shows irritation. These symptoms appear late and assume a chronic course. Acne, eczema and boils develop on different parts of the body. And there is eczema in the axilla and bend of the elbow. The glandular system shows irritation and the glands in various parts of the body are enlarged, and furuncles and suppuration appear at many points, wherever there is irritation. The sensation attending the pain is variously described in different portions of the body; itching and burning of the skin; aching of the head, stomach and abdomen; tearing in the teeth; pinching in the abdomen; drawing in the abdomen and extremities; and stitching in the abdomen, chest, back and anus.

This remedy should be studied in cases of fermentative dyspepsia and intestinal indigestion, and fermentation when the appetite remains good. The whole abdomen is distended and tympanitic. There is rumbling of gas in the stomach and bowels, with frequent eructations and a profuse emission of flatus; with a frequent desire for stool. The latter is semi-solid or liquid. There is burning in the anus during and following the stool.

It is indicated in cases of toxic headache, when this is attended with mental confusion, heaviness of the head and the face is flushed. There is throbbing in the temples and the condition is attended with excessive fermentation along the gastro-intestinal tract. The headache is partially relieved while in the open air.

There is an abnormal amount of urine secreted. There may be irrita-

tion of the bladder, and as a result there is a constant urging to urinate or there is dribbling of the urine.

It may become the remedy in rheumatic arthritis, when the pains are referred to the knees, interfere with locomotion and are attended with more or less gastro-intestinal disturbances and fermentation.

It should always be remembered in cases of disease of the skin, especially when attended with glandular enlargement, and other indications of scrofula. In these cases it has been employed in the tincture and in an infusion.

It will be found curative in *crusta lactea* or *tinea favosa*, when there is soreness on or behind the ears. The scalp is red and there is violent itching of the parts at night. There are scales and itching in the axilla. It should be studied in these cases when they are characterized by marked gastro-intestinal fermentation, in which there is a continuous eructation, and passing of flatus. Associated with this there is often a frontal headache and diarrhœic stools that are attended with burning at the anus. There is more or less pain through the abdomen and especially at the splenic flexure of the colon. The quantity of urine secreted is much increased.

It is indicated in cases of incarcerated flatus, when this occurs in the region of the splenic flexure of the colon, although the whole gastro-intestinal tract is distended and the stools are liquid.

Dr. Souberbielle considered it a specific in cases of catarrhal jaundice. He macerated one drachm of the dry and powdered leaves in a sufficient quantity of white wine. This the patient took before breakfast.

Dr. Funke reports a case of malarial fever of the quartan type, for the relief of which quinine and all other remedies had been tried. An infusion of two drachms of the green envelope in six ounces of mint water was given once a day with prompt and positive results.

Professor Negrier employed it extensively in his hospital for scrofulous children. He used an infusion of the leaves locally to bathe the open sores and gave it internally with most positive results.—*Century*, Jan., 1912.

**LACTIC ACID.**—Diabetes has been relieved—the reports say cured—with lactic acid when the patients suffered with rheumatic pains in addition to their other symptoms.—*Jan. Century*.

**TARANTULA IN NYMPHOMANIA.**—This is a very effectual remedy when the following symptoms are present: Menses too profuse and too early; excitement, leucorrhœa, itching of the vulva, and pains and spasms in the uterus. Tarentula 3, two drops taken every hour until relieved, and then less frequently, soon produces a decided improvement and eventual cure.—*Jan. Century*.

**ALLIUM CEPA.**—Is a friend many times annually in its speedy arrest of coryza with its well-known modalities, a good remedy with which to convince doubting nurses and allopathic physicians (sometimes) of the efficacy of a therapeutic law.

**REMEDIES FOR THE ONSET OF APPENDICITIS.**—Belladonna, Colocynthis, Aconite or Ferrum phosphoricum are the remedies for the onset. Bel-



ladonna is incontestably the remedy most often employed at the onset of appendicitis in Europe as in America. It is preferably given in low dilution—Hale 1x, Jousset 2x, Sieffert tinct., Purdom 1x. Others as Olive y Gros, employed the 30 or the 1,000. Belladonna (article extracted from *L'Art Medical*) is more indicated than opium, corresponds to the pain, vomiting and especially to the intestinal inertia, and the absence of evacuations by the anus. According to Mitchell (North Am., 1896) Belladonna relieves the pain, diminishes the hyperæmia and the consecutive lesions, calms the nervous system, reduces the temperature and the pulse. However, it is my opinion, as I have said under typhilitis, to insist too long upon Belladonna if the disease follows its course or becomes worse is to lose precious time. I have often given belladonna at the onset without being able to prevent the attack. The application of ice to the cæcum is a good method of diminishing the congestion and the pain. As to Colocynth, I have already praised this remedy enough in the article on colic, acute enterocolitis and typhilitis to repeat here. The griping pain, forcing the patient to bend double, is always the indication for colocynth. Pains that are too sharp are a contra-indication for Aconite, according to Dewey. If an influenzal form of appendicitis is suspected I strongly advise to commence with *Rhus radicans* 6, ten drops per day.

In the actual period the chief remedies are bryonia, dioscorœa, *mercurius dulcis*. If belladonna is indicated by most authors as the remedy for the onset of the disease bryonia is no less the one for the established attack, characterized by steady pain, but less severe than that of colocynth; worse from pressure and motion; in a word the true inflammation of the tissue of the appendix or cæcum in the neighborhood of the peritoneum. Olive y Gros only advises bryonia when the patient has had a passage, although bryonia is a remedy characterized by constipation.

Many other authors mention *mercurius*, preferably *mercurius dulcis*; others *corrosivus*. I have used them rarely. *Mercurius* being homœopathic to inflammations of the mucous membranes, says Dewey, merits consideration, especially if there be a hard swelling, fever, face puffed and red, dry tongue, etc. I would more willingly insist upon dioscorœa viilosa, which is likewise much employed by my confreres, Craig among others. Under the article typhilitis I have likewise indicated the analogy between dioscorœa and colocynth in intestinal pain. The first is differentiated from the second by the relief in stretching out, according to Clark's Dictionary, while colocynth has an amelioration by bending double. I think that dioscorœa has a deeper action than colocynth and that it corresponds well to the actual period of attack of appendicitis. There is also a fluid extract prepared, called dioscorinum, that I had occasion to employ formerly while I was physician in L'Hopital St. Jacques. I recall a typical case treated alone with dioscorœa 3, followed by dioscorinum 6, ten drops a day. The zigzag fever, 38.4 C. evenings, left in six days; the tumor, quite distinct and voluminous, disappeared in fifteen days.—*Medical Century*.

RANDOM NOTES ON THE MATERIA MEDICA.—By R. F. Rabe, M. D.—*Ranunculus bulbosus*, the buttercup, is frequently overlooked in the treatment of myalgia or pleuritic pains. Bryonia is confounded with it many

times. The pains of *Ranunculus* are sore as though the muscles of the chest wall had been bruised. Stitching, cutting pains are also present and very severe. *Ranunculus* is aggravated by motion such as turning from one side to the other while lying in bed, by deep inspiration, which is exceedingly painful. In these respects it can hardly be distinguished from *Bryonia*, but unlike the latter remedy, *Ranunculus* cannot lie upon the painful side. *Bryonia* perhaps more often typifies a true pleurisy. *Ranunculus* a pleurodynia. *Arnica* resembles it but the history points to a trauma as a cause. Both are sore to touch. *Arnica* has marked fear of touch or of anyone approaching. In herpes zoster of the intercostal or supraorbital nerves *Ranunculus* is a most valuable remedy. The eruption is a vesicular one, burning, the vesicles being bluish-black in appearance. In this affection *Rhus tox.* is often indicated, the characteristic *Rhus* restlessness and temporary relief from motion being present. *Cantharis* demands a place in the therapeutics of shingles, but here the vesicles contain a hot, burning, excoriating serum and some degree of bladder irritability with more or less burning on micturition will be present. *Mezereum* is useful in zona when intense neuralgic pains appear after the eruption has gone.

In chronic catarrhal inflammations of the throat, with much dryness, ameliorated after eating, *Gistus canadensis* is indicated. Sensitiveness to the inhaled cold air and soreness are further symptoms. The glands of the throat may be enlarged.

Ineffectual urging to sneeze is a symptom sometimes met with, and although common to a number of remedies, is strongly characteristic of *Carbo veg.* and *Silicea*.

Nausea and faintness mornings before breakfast and ameliorated after, call loudly for *Sepia*, and, if the complexion be dusky with chloasma present, the choice is certain. Postnasal catarrh with the discharge of large dark chunks of hardened mucus is relieved by this remedy also, but *Elaps corallinus*, the Brazilian coral snake, is a strong competitor. *Sepia* has a morning and evening aggravation with a remission of symptoms during the day. Its cough is loose mornings and seems to come from the stomach. Mentally, *Sepia* resembles *Pulsatilla* and especially *Natrum mur.*, having not only the tearful sadness of the former, but the tearfulness and depression with aversion to consolation of the latter. *Pulsatilla* is approachable and can be consoled; in fact, rather seeks the solace of kindly interest. *Natrum mur.* and *Sepia* are averse to petting, resenting any interference no matter how well disposed and want to be left alone. *Sepia* adds a peculiar indifference to the picture, taking no interest in the things which normally are most important. *Sepia* and *Natrum mur.* are complementary in action, one being often required to complete the work begun by the other. *Nux vomica* is frequently the acute remedy of *Sepia*, while *Ignatia* bears the same relation to *Natrum mur.* The acute effects of grief are best controlled by the former, the chronic results by the latter.

Causal relationships are important factors in prescribing. The abdominal or gastric complaints, which date from the kick of a horse, will often be entirely cured by *Arnica*, even though the symptoms manifested be not found in the published pathogenesis. But where the skiagram reveals an enteroptosis to which the symptoms are due, *Arnica* will fail.

Mechanical support becomes necessary, again illustrating the fact that diagnosis is essential to good homœopathy.

Acute frost-bite is best met by the application of vigorous friction with snow or cold water, but internally by *Agaricus muscarius*, which is nine times out of ten the needful remedy. Chilblains may also demand *agaricus*, but *Petroleum* and *Pulsatilla* must not be forgotten. The former is necessary when the chilblains come on with the cold weather, when they are moist, and itching is pronounced. The latter relieves when the appearance of the chilblains is dark bluish and the suffering aggravated indoors.

In gastralgia the symptom of pain relieved by eating is met by *Chelidonium*, *Graphites*, *Petroleum* and *Anacardium*. Concomitant symptoms will, of course, determine the choice. *Chelidonium* craves hot food and drink and usually betrays some functional hepatic disturbance. *Graphites* is obese, chilly and hepatic. Constipation is pronounced, though foul-smelling, loose, dark stools in the forenoon may occur. Glutinous discharges are characteristic. *Petroleum* presents a marked skin phase to its condition with eruptions appearing or worse in winter. Rhagades are common, though also found in *Graphites*. Diarrhœa in summer is common to *Petroleum* and occurs during the daytime only. Cold sensations in the abdomen and occipital headache are further indications. *Anacardium* typifies the more neurotic type of case perhaps; weak memory or a tendency to swear and curse may manifest themselves. Pains are spoken of as blunt or as though a plug were pressing into the effected part. *Anacardium* is directly opposed to *Nux vomica* in that the patient is better on a full stomach, whereas *Nux* feels better as his stomach becomes more empty and digestion is completed. Both are irritable, though *Nux* the more so.

*Nux* can stand fats and rather likes them. *Pulsatilla* cannot digest fats and has an aversion to them. The same is true of *Ptelea trifoliata* and of *Carbo vegetabilis*. Nausea from the odor of cooking is a symptom common to several remedies. *Colchicum* has it in the highest degree, but *Arsenicum*, *Digitalis*, *Ipecac* and *Sepia* have it also nearly as well marked. Again concomitants must decide.

The keynote presented are handy hints to have hovering about and serve to lighten the often laborious search for the *Simillimum*. Dozens more might be cited but time and space forbid.—*January Chironian*.

**CAUSTICUM.**—There is a form of constipation in which I have always seen good results from this medicine. The evacuation is very solid, is expelled with great difficulty and straining, and presents a shining not arising from ascarides, but on appearance as if greased. I have also seen it useful in itching of the anus, sometimes with a small rash, and at others by an oozing of mucus.—*Bayes. Feb. Pacific Coast Journal*.

**CAPSICUM.**—Is the remedy in relaxed sore throat. The fauces and pharynx are dusky red and the uvula elongated and œdematous. It is specific in the early stages as a gargle, one dram of the tincture to half a pint of water. The throat of *capsicum* is red, but has more burning and stinging pain and less febrile disturbance than *belladonna*. The faucial tissues are more baggy. Here we have burning in fauces, parts most sore



and tender, ulceration presents sharply defined ragged edges with indolent adjacent tissue. It is a potent remedy for the cure or mitigation of pellagra.—*Feb. Pacific Coast Journal.*

ABROTANUM.—Produces and cures many paretic symptoms. Hands and wrists weak, reins drop while driving, pain in shoulders, arms, wrists and ankles. Pricking and coldness in fingers and feet. Neck so weak, cannot hold head up. Back lame, weak and painful. Use the sixth potency.—*Feb. Pacific Coast Journal.*

KAOLIN in the lower trituration is a valuable remedy in croup and bronchitis. There is soreness of the chest along the trachea, cannot stand percussion. Capillary bronchitis.—*Feb. Pacific Coast Journal.*

DULCAMARA is one of the best remedies for herpetic symptoms on the face, especially in children. Humid eruptions on cheeks, warts and thick, brown or yellow crusts on face. It is the remedy par excellence for urticaria, specially when the trouble is worse or comes on when weather changes from hot to cold or damp.—*Feb. Pacific Coast Journal.*

AETHUSA.—Acute conditions that set in with violence, brain symptoms and most marked inability to digest milk call for this remedy. During dentition, gastro-intestinal disease with much anxiety, crying, uneasiness, child "see things"—rats, cats, etc.

*Objective Symptoms.*—The eyes are drawn downwards, pupils dilated, face is puffed, staring eyes, child lies unconscious, the linea nasalis marked, aphthæ. Surface of body cold and covered with clammy sweat. Must be covered during sweat. Violent startings during sleep. Itching eruptions around joints. Violent vomiting of curdled milk as soon as taken.—*Feb. Pacific Coast Journal.*

PICRIC ACID is indicated in chlorotic states, with loss of vitality and general deterioration of the blood. Patient is cold and weary, physically and mentally. Use the 6x, three times daily.—*Feb. Pacific Coast Journal.*

ANTIMONIUM CRUDUM is a grand remedy for rheumatism in the feet when the soles are so sensitive that patient can hardly step on them.—*Feb. Pacific Coast Journal.*

CALCIUM SALTS IN MENSTRUATION.—The regular performance of menstruation appears to depend on the periodical fluctuations of calcium metabolism in the system. Thus, in amenorrhœa from general debility, there is said to be too little calcium to permit menstruation. Hence, calcium lactate in large doses as a tonic is recently recommended. Homœopathically, calcium assists to restore the power of assimilation of calcium salts from the food. Secondly, it is found that the fall in calcium percentage noted at the commencement of menstruation was immediately followed by a rise, and that unless this occurred the flow did not cease and menorrhagia resulted. This condition seems to be due to deficiency of calcium salts in blood, and hence calcium as a homœopathic remedy.—*Feb. Pacific Coast Journal.*

# THE HAHNEMANNIAN MONTHLY.

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MAY, 1912

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## PRESIDENTIAL ADDRESS.

DELIVERED BEFORE THE HOMOEOPATHIC MEDICAL SOCIETY OF  
THE STATE OF PENNSYLVANIA, BEDFORD SPRINGS, PA.,  
SEPTEMBER, 1911.

BY

WILLIAM A. STEWART, M. D., PITTSBURG, PA.

I WISH to express my deep appreciation of the honor you have conferred in choosing me your Executive Officer for the year 1911. I deem it the greatest privilege to be permitted to labor for the cause dear to the hearts of us all. I shall endeavor to discuss in a straightforward, common sense way a few topics that I believe to be of VITAL importance to this Society.

Pennsylvania enjoys the distinction of having one of its members chosen this year Executive Officer of American Institute of Homœopathy. They have also chosen Pittsburgh as their place of meeting. I bespeak the loyalty and hearty support of every member of this Society to this splendid organization.

I would recommend that this body appoint a committee to aid President Carmichael and the local committees.

Pennsylvania already has the largest State Society in the United States and she ought to be able very easily to work up the largest enthusiasm in our National organization.

## LEGISLATION.

The supposition has always been that the public desired medical legislation for *its own* protection, that the quacks and charlatans might not be at liberty to prey upon the credulity of sick people and dope them with all sorts of nauseous and harmful drugs and subject them to unskilful manipulations, but the contrary seems to be the case. It developed in the last session of the State Legislature that the only people, of whom the dear sweet public is afraid, are the regular practitioners of medicine. They have made it perfectly easy for everybody but a doctor to practice medicine in this State, and they have hedged him about by all sorts of fool restrictions. If the public can stand it, we ought to be able to. The doctoring business is not so different from other kinds of business. It is largely a question of supply and demand and a case of the survival of the fittest.

In noting the trend of medical legislation for the last decade one is able to arrive at but one conclusion, namely, that the sole purpose of it all is not in any sense to protect the public, or to educate better doctors, but to make fewer doctors, regulate prices, kill competition, and seek the balance of power in political parties. In proof of this I wish to quote from the Annual Address of the President of the American Medical Association, Doctor Murphy. In speaking of the work of the Council of Medical Education, he says:

"The Council of Medical Education of which my colleague, Doctor A. D. Bevan is chairman, has won distinction, and should receive the highest commendation of this organization. The number of medical colleges in the United States granting degrees has been decreased through the efforts of this committee from 166 in 1904 to 129 in 1911. Of this number only sixty are doing acceptable work. The number of medical students has been reduced from 28,142 in 1904, to 21,526 in 1910, and the number of graduates for the same period from 5,744 to 4,440."

We will probably have to admit that our friends of the dominant school are better politicians than we are, for they have apparently succeeded in forming a medical trust. Our contention is, however, that the medical profession has no right to form itself into a great political machine or trust for the sole purpose of controlling legislation and limiting competition.



Organization that has for its chief end the acquisition of arbitrary power is unquestionably contrary to public policy and cannot endure. As a school of medicine we are in need of no such protection, and I hope we are honest enough not to desire it. We seek organization, the sort that will enable every man to do his best work, and the homœopathic profession to foster and perfect the only scientific law of therapeutics that has ever been devised.

The question then arises, What is the legitimate end of medical legislation? This, in my judgment, is a very pertinent question, and one that this Society is called upon to answer. It is one that should not have in its solution one vestige of selfishness or vindictiveness. The fact that bills have been recommended and laws placed on the statute books which had for their ultimate object the annihilation of our school is no reason why we should stultify ourselves by recommending similar legislation. Our position will only be tenable in so far as, in the future, as we have always done in the past, we advocate legislation that clearly has for its object the most perfect protection of the laity and the education of better doctors to care for them when they fall ill. Nor do I believe that we should always condemn the measures advocated by the dominant school and imagine that they are all framed with an ulterior motive. Most of the legislation recommended along the lines of sanitary science and preventive medicine is sound and should meet with our commendation. It is safe to conclude that a large majority of the members of the dominant school are high minded, honest medical gentlemen and their opinions are quite as worthy of consideration as those emanating from members of our own school. After reading carefully the address of Doctor Murphy, already quoted, one can arrive at no other conclusion. While many of his suggestions cannot be endorsed, they are undoubtedly honest. What he has to say on the ethics of the profession is so high minded that I take the liberty of calling your attention to this paragraph:

"Now I have the unpleasant and most painful duty to perform, and that is to call the body's attention to the shortcomings of the medical profession.

"There is a common, insidious and deadly parasite eating at the root of public medical confidence and that is the practice of medical fee division, commission paying, and the sale and purchase of patients. We should see to it that no man of our

profession barter to the highest bidder in commission and fee divisions. He who offers or gives is morally as guilty as he who requests or receives and no sophistry should be accepted in justification of this atrocious practice. The money changers of the profession must be driven out of the Temple of Aesculapius as they were driven from the Temples of Religion."

This whole subject of medical legislation should be so thoroughly considered that the individual members of this body would comprehend it in its every detail and its various bearings on the individual, the colleges and the school as a whole.

It is not the function of the legislature of the Commonwealth of Pennsylvania to help a lot of dawdling doctors make up what they call their minds. If we can determine the sort of legislation that will raise the efficiency of the medical profession so that its members will be not only able to prevent but cure disease, and can convince the law makers that we stand as a unit, twelve hundred strong, men with but a single purpose and with no ulterior motive, we shall be able to defend our position, even as Xenophon's ten thousand held the millions of Persian marauders at bay.

Assuming then that the chief object of medical legislation is to raise the efficiency of prospective doctors, what have we to expect from the present method of waiting until after the doctor has received his degree and then pass on his fitness to undertake the healing art? Is it not a fact that all doubtful candidates sooner or later succeed in getting a license to practice? Is it not more rational to undertake to produce a better product rather than to devise means of keeping those who are poorly prepared out of the profession? This was the position taken by our Legislative Committee in the bill that they presented to the last State Legislature. We believe that the principles set forth in this bill must be recognized as sound, and the solution of this problem.

But we must go one step further. We must inquire into the subject of medical education.

We are all agreed that we want the best, but just what constitutes the best? We hear certain educators wax eloquent on the subject of a college education as the only rational preliminary requirement. They talk about the training of the mind and the development of gray matter, but what are the real needs in the case? It will certainly be a misfortune if we

find that the time required to complete a medical education is so long that it practically prohibits the young man of moderate means from becoming a doctor. There is no gainsaying the fact that in the past this class of boys has been drawn upon very largely for the brilliant minds in medicine. I believe that we as a school are better fitted to decide this point than the dominant school because we are not prejudiced by the belief that the medical profession is overcrowded.

Medical educators seem to be the only ones who have not exploded the idea that to study abstract subjects in some way brings about a better development of the mental faculties than the pursuit of practical subjects that have some bearing on one's life work. If instead of saying to the prospective student of medicine, spend so many thousand hours or so many years in academic study, it matters not what the subjects are or how remote they may be to medicine, on the theory that this is the best way to develop human intelligence, we would say, begin in the high school and pursue such and such subjects in a definite order, it is my belief that a broader foundation for medicine would be laid, just as much mental development would result, in fact an equal culture would be obtained, and several years of valuable time and much expense would be saved.

It is not my purpose to outline this course of study, or to state the length of time necessary for its completion. Suffice it to say that it should begin with the high school and should proceed without interruption, each course leading up to the next in a logical sequence, until the whole subject of general medicine has been covered. My belief is that four years of preliminary work and three years of didactic work in a medical college will be sufficient time. The fourth, and if the consensus of opinion is that we should have a fifth year, should be devoted to clinical work or applied medicine. The teaching of applied medicine has not until recently received the consideration it deserved. I am happy to state that this sort of teaching is being done at the present time in the Hahnemann College in Philadelphia in a most efficient manner. The students in groups of two are taken into the wards, given cases to examine, diagnose and treat under the direction of a capable clinical instructor. As Dean Van Lennep said to me, "The cases are treated homœopathically." This work is particularly important to homœopaths, as our method of practice contains



nothing of empiricism, but is dependent on a careful individualizing and an equally careful taking of every case and finding its similimum. I am convinced that the indifferent homœopath is he who has never acquired this art. Formerly this skill was acquired by a long and intimate association with a preceptor. The preceptor went out of fashion more than a generation ago and our medical colleges until very recently have not supplied this instruction in applied homœopathy. If it be true that there is a deal of indifferent quasi-homœopathy abroad in the land, it is my belief that both the cause and the remedy are patent.

Again the microscope and the chemical laboratory have in the last two decades developed much information of a very high scientific value. It has thrown a vast deal of light on the causes and etiology of disease, but just what assistance has it been in curing the sick? Has it enabled us to make a better prescription, or has it modified our methods to any great extent? It seems rational that this knowledge will ultimately be found to bear a very direct relation to the treatment of disease. Our faith in the curative property of drugs makes us the logical school to undertake this vast work. I believe that many of our symptoms would be explained and their application be made much more accurate if they were carefully studied in the light of all these findings. This work cannot be successfully done by the busy practitioner but must be done by our colleges and laboratories, supported and sustained by the loyalty and enthusiasm of the entire homœopathic profession. This work calls for the hearty co-operation of every homœopath in the State. It is big enough and important enough so that in its well doing there will be glory enough for all. We have a peculiar knowledge of the healing art, a knowledge that evidently the rank and file of the dominant school do not covet. It is the same knowledge that has enabled the homœopaths since the days of Hahnemann to inspire the people with confidence and enthusiasm and it is just as potent now as it has ever been.

**THE LIMITS TO THE SCOPE OF THE HOMŒOPATHIC REMEDY.**

BY

E. M. HOWARD, M. D., CAMDEN, N. J.

(Read before the Homœopathic Medical Society of the State of New Jersey.)

So wonderful were the results obtained by the earlier homœopaths, not only in comparison with those observed by the dominant school, but transcending all their own reasonable expectations, that our pioneers were led to claim a far wider scope for our law of cure than later experience and more definite knowledge can substantiate. The sometime miraculous effects of small doses were so wonderful as to lead them to claim the applicability of the homœopathic method to nearly all the ills of the human race, and likewise made them discard and deprecate every other method of medical procedure. Such enthusiasm led them far astray and was partly responsible for the ridicule and ostracism on the part of the dominant school.

The older homœopaths were excusable for such mistakes. Hahnemann lighted a lantern which shone with great distinctness in the impenetrable darkness of the medical age in which he lived, but which in the sunlight of the great advances of scientific knowledge and diagnostic ability of the present time does not appear quite so brilliant, and has become in fact almost overshadowed in the eyes of some of our own practitioners. It seems pertinent, therefore, that we examine the question of the possible limits of the homœopathic law.

The law of similars is first of all a law of cure. It relates only to such action upon diseased cellular structure as will tend to re-establish normal functions. Before there can be any such curative action by any drug it is absolutely necessary that first, the cause of the condition, if still acting, shall be removed. *Tolle causam* was the motto of the ancient physicians; it was emphasized by Hahnemann and still demands first attention. It is sheer folly to look for any curative result from a drug while the cause is still present and active. This is evident enough when we consider such simple conditions as a splinter in the hand, a foreign body in the eye, or a poison free in the stomach. It is therefore evident that the homœopathic remedy is not applicable when there exists a distinct mechanical or chemical cause. Such causes must first be removed before any

curative action can be supposed, or the law of homœopathy be given any consideration.

Modern science has wonderfully enlarged our conception of what may constitute mechanical causes of disease. Modern diagnostic methods have brought to light many unsuspected mechanical causes and conditions mechanically interfering with usual functions, and the great field of bacteriological investigation has opened up new questions of this nature, materially widening our view of the causes of disease.

It would seem then that we may lay down a general law to the effect that whenever modern science can demonstrate the presence of a distinct mechanical agent as the cause of a given diseased condition, other methods than the homœopathic remedies are indicated and that such foreign bodies or obstructions must be disposed of before we enter the sphere of the law of similars.

It thus becomes apparent that the law of similars is not the only law to guide the physician in the practice of his art, and that although it is the only known guide to the relationship of drug power to curative processes, it is only one of many laws that must be utilized for the relief of ailing humanity.

The physician requires a knowledge of and uses many such laws in his work. Mechanical laws and antiseptic laws in surgical cases, chemical laws in poison cases, electrical laws, hygienic laws, dietetic laws, and many others must be and are applied by every practitioner in his care of the sick. I deem it, however, very essential that we more carefully differentiate the attempts we make by means of drug power for the removal of *causes* of disease, from those that we make for the cure of abnormal vital processes.

The common uses made of drugs as antiseptics, caustics, purgatives, emetics, mydriatics, myotics, anthelmintics, oxytoxics, etc., are plainly based upon the removal of mechanical conditions, and so belong entirely outside the realm of homœopathy, and in the field of pharmaco-mechanics. The use of anaesthetics, analgesics and hypnotics points out another field of therapeutics mainly outside the scope of the law of similars. It is true that use of analgesics and hypnotics in curable cases is open to discussion, but in incurable and hopeless suffering, their application is certainly legitimate and obligatory, from an humanitarian standpoint.

After demonstrable morbid causes have been removed, there



remain resulting conditions which do not readily disappear. All such come within the field of the homœopathic remedy.

Again in those vast realms, where as yet science has not revealed a demonstrable cause of the morbid condition, there exists a great field of ill health and suffering, which must be relieved, if at all, by the homœopathic remedy. Experience for a hundred years has shown that many of these conditions are more or less promptly relieved by the application of drugs in accordance with the law of similars, and for them no other intelligent mode of treatment exists.

This law of similars enables us to attack disease in its beginnings; at the very first deviations of cell vitality, and to unerringly apply the right remedy. The only guide we have to such deviations are the sensations of the patient. Disturbance of cell physiology is known only by symptoms which appear long before there is demonstrable pathological changes, and such manifestations are peculiar and characteristic to each individual. The only way we can find a drug capable of restoring such deviations to the normal, is to find one that acts upon the same elemental cells and forces in a similar manner, in other words, one that can or has produced the same identical train of symptoms, with the same characteristics. The selection of drugs in accordance with the law of similars, therefore, stands upon a reasonable and scientific basis in spite of the fact that we are dealing with elements beyond the range of the microscope, or any other method of modern research.

There exists a period antedating the existence of a definite pathology where chronic diseases and neoplasms are in their beginnings, when vital processes first deviate from the normal. If one controls them then we will prevent further development. Herein lies the dream and hope of the future for the prevention of malignant disease.

In trying to define the limits of the scope of the homœopathic law, it is easy to find extremes concerning which there can be no question, but there is a middle ground for honest doubt and discussion. A broken bone, or a fibroid tumor, or a urethral stricture, are conditions which must be reached, if reached at all, by mechanical measures. On the other hand, no one who has observed the quick relief and perfect control of spasmodic croup by such drugs as aconite or spongia, or of neuralgias by belladonna and colocynth could doubt the efficacy of such treatment, and we must place all such applications within the sphere

of homœopathy. Between such extremes there exist many conditions in which the limitations are not so clear, and others wherein there seems to be a real overlapping of the different methods of treatment. It is not yet certain whether the great success of homœopathy in treating such diseases as pneumonia and typhoid fever has been excelled by the curative methods based upon bacteriological discoveries. It is still uncertain how far bacteriological study will limit the homœopathic field of cure. Just now the antitoxins seem to have cut out large slices from it, and doubtless many more discoveries will be made limiting the scope of its law. There will, however, always remain conditions after the toxins have been destroyed calling for the use of curative remedies. The great mass of functional diseases, from whatever standpoint we may view them, will always need homœopathic medication, and alone, if there were no other uses, would demand for all time the development and perfection of the applicability of drugs according to the law of similars.

There is another phase of this subject which adds to the confusion concerning the limits of the law of similars. We do not make sufficient distinctions between the different ways individual drugs are used in practice. We have failed to place sufficient importance upon the fact that sometimes we use certain drugs to remove foreign bodies, and sometimes we use these same drugs to produce definite curative results. Sometimes we use drugs to overcome certain definite mechanical conditions, and sometimes we use the same drugs in different doses to cure the results of such mechanical conditions. Sometimes we make use of some one of the more prominent physiological effects of a drug to accomplish some one definite effect in accordance with definite mechanical principles, and sometimes we base our prescriptions upon the entire symptomatology of the drug, relying entirely upon the law of similars. A careful analysis will show that these are the lines of division between the two schools of medical philosophy. Old school medication (all that is not purely empirical) is based upon the use of drug forces for the production of definite mechanical or chemical effects. To dilate the pupil of the eye; to evacuate the stomach or bowels; to control the vaso motor circulation; to stimulate the heart's action; to increase elimination; to deaden pain, etc. These are generally reasonable and legitimate and of great value to hu-

manity when wisely guarded, and belong equally to all practitioners of the healing art. Such uses, however, are hampered and restricted by the other and wider physiological effects of the drugs, which are annoying and undesirable, and the effort to get rid of which is responsible for much of polypharmacy. This constitutes what I think should be called pharmacomechanics. It occupies a field by itself, is absolutely independent of any other uses of the same drugs, and is governed by mechanical laws.

On the other hand, the homœopathic practitioner approaches the problem of disease from another angle. Having faith in the law of similars he selects his drug from the totality of the drug symptomatology, omitting no detail or effect as unimportant, calling every symptom to his aid in selecting the closest similar. The real curative results obtained have justified such means, and this way of using drugs, I think, should be called pharmacodynamics.

The old school has but little faith in use of drugs that cannot be justified upon pharmacomechanical grounds. They have, therefore, little faith in the curative effects of our remedies. Such curative agents as they do recognize, like quinine in malaria, mercury in syphilis, or the salicylates in rheumatism, etc., they are disposed to explain upon bacteriological grounds. Although this possibly may be a true explanation of their cure, nevertheless they are also splendid illustrations of the law of similars as these drugs produce a perfect picture of these diseases. In this way we can also explain all the beneficial effects which empirical practice has endorsed in all medical experience, outside of self evident drug mechanics.

It appears, therefore, that the real physician must determine at the bedside of his patient the applicability of these methods. If there be a removable cause, he must determine what agent is best to remove it, whether it be physical, or surgical or medicinal. It is not only proper and his right, though a homœopath, but more, it is his duty, to choose the best agent for this purpose. In so doing he is not disloyal to homœopathy but honoring it by accurately outlining its scope. If there be no removable cause and the case is incurable, he must resort to such measures, whether by drugs or otherwise, as will best alleviate the patient's suffering.

Most other conditions demand of us the careful applications of drugs in accordance with Hahnemann's method.



The real region of doubt between the two schools is that great field where the question arises as to how far the apparent efforts of nature to restore equilibrium shall be aided or retarded. We think the heart is beating too forcibly. Shall we soften it? It is too rapid and weak, Shall we strengthen it? Elimination, we think, is too active, Shall we check it? Here is the field for honest doubt and honest difference of opinion. But does it not seem safer to trust to what has been demonstrated to be an eternal law of the relationships between the action of drugs and the cure of such conditions, rather than trust to our own finite judgment and knowledge as to the requirements of nature's processes?

In this brief manner I have tried to outline the following points:

That we should carefully separate the attempts we make for the removal of the causes of disease from those we make for their cure.

That we must carefully distinguish between the use we make of drugs to produce mechanical results, best called *pharmacomechanics*, from our use of the very same drugs, in other doses, for the *cure* of abnormal conditions, which use is best defined by the term *pharmaco-dynamics*.

That the entire field of mechanical causes, and all obstructing conditions removable by mechanical means, are entirely outside the scope of the homœopathic law of cure, and must be met in conformance with other laws.

The relief of incurable pain is also a domain mainly outside the law of similars, belonging in the same analgesic category as the use of anaesthetics.

That all conditions following or remaining after the removal of mechanical causes, belong strictly in the domain of the homœopathic law.

All functional conditions belong distinctly in that field.

That the homœopathic method is the only hope for the prevention of chronic diseases and neoplasms.

That the only real overlapping is in the bacteriological field, and the point of controversy concerns the apparent efforts of nature and our ideas concerning them.

**A CONSIDERATION OF LACERATIONS OF THE PERINEUM IMMEDIATELY FOLLOWING LABOR.**

BY

JOHN EDWIN JAMES, JR., PHILADELPHIA.

(Read before the Wm. B. Van Lennep Clinical Club, November, 1911.)

No foreword is necessary to emphasize the importance of this subject, no matter what may be the familiarity with it possessed by those of you who will do me the honor of attention. Only this I would say, that the day when physicians, in attendance upon obstetrical cases, fail to examine the birth canal for lacerations immediately following delivery, or, in examining, fail to recognize a laceration, is long since passed. We can very justly smile with pity upon the man who will boast of a large number of cases delivered by him without sustaining a tear of vagina or perineum, and in response, state what a percentage of our cases,—a large percentage at that,—show a laceration of one degree or another; thereby perhaps evidencing our greater skill as diagnosticians and, incidentally, our greater skill in the proper or complete management of labor cases. As a matter of fact, every obstetrical clinic of any size whatsoever, where careful, conscientious work is done, will show that in over 66 2-3 per cent. of all primipara, and 10 per cent. of all multipara, there will be a laceration of the lower birth canal of some degree; and where such statistics obtain in reputable clinics, it must be the experience in private work. The citation of these facts I would not have any one consider as an excuse for the careless physician, for the one who does not attempt to conserve the integrity of the perineum in every case he attends; they serve to show us the frequency of this condition after birth, in the hands of the most skilled, and consequently the importance of the consideration of the same from time to time, to point out the absolute duty of every physician in recognizing a laceration and to accurately repair, in order to offset the grave possibilities which follow in the wake of neglect and ignorance, leading on to subsequent operations and even with these, in many cases, to constant pelvic distress amounting practically to chronic invalidism.

The basic knowledge of this subject forms a most essential

part of the obstetrician; and this means every physician who will attend a woman in labor and not simply the specialist. Some one has aptly said, "It would be well if every surgeon before practicing operations for the cure of lacerations of the perineum could serve an obstetrical apprenticeship and thus learn the nature of the lacerations from a study of their details immediately after birth,"—and to this I would add, every physician should have a thorough, practical training in immediate perineal lacerations, their details and methods of repair, before attempting obstetrical work in private practice. The complements of such a knowledge consist in a study of the anatomy of the pelvic floor; its functions and alterations during labor; the methods of best conserving its functions and integrity at birth, and accurate anatomical repair. As Webster points out, the term "perineal body is liable to misinterpretation; the perineal body should not be studied as a separate entity. It is merely the anterior portion of the sacral segment of the pelvic floor, and is a complex structure composed of different fascial and muscular structures." The entire pelvic floor then we must study and dissect; note its physiology and the effect of attenuations and lacerations as a whole upon neighboring and supported structures and organs.

In so far as the anatomical consideration is concerned, we can describe the pelvic floor, following Williams, as consisting of all the structures between skin externally and peritoneum internally, which enclose the pelvic outlet, and perforated by rectum, vagina and urethra. Beneath integument we find the external pelvic and perineal fascia, embracing the superficial muscles, viz., bulbo-cavernosa, ischio-cavernosa, superficial transversus perinei, sphincter ani, sphincter vaginae; then, the deeper muscular layer consisting principally of the levator ani and coccygeus; next, the internal pelvic fascia, and lastly, the peritoneum. This complex structure we divide, obstetrically, into two segments, viz.: (a) the anterior, or pelvic, lying between symphysis pubis and vagina; (b) posterior or sacral, between vagina and posterior bony pelvic wall, embracing the so-called perineal body. I would emphasize the levator ani muscle, the sling muscle of the pelvic outlet so to speak, as one of the most essential of all the structures from the supportive view point, and the one most subject to injury and laceration at birth. Extending from pubic ramus anteriorly to tendinous raphe between rectum and coccyx, posteriorly, encircling va-



gina and rectum, it is easily subject to variable degrees of injury.

During labor, with descent of the presenting part to the pelvic floor, changes occur in the perineum in the way of mechanical dilatation and expansion from pressure. The anterior segment is crowded forward against the symphysis pubis and is but rarely lacerated by the presenting part, *per se*. The posterior segment receives most of the brunt, it becomes thinned out, distended, hence, "bulging," and eventually, according to Williams, forms the "perineal gutter" which, he tells us, aids in directing the presenting part forward towards the outlet, and which, I believe, brings about a certain alteration in the parturient canal as to its shape, which plays a most important role in one of the most important steps in the mechanism of labor,—the internal anterior rotation. It is in this segment lacerations necessarily are most frequently seen.

And now, just a word in relation to the duty of the attending physician in the conservation of the integrity of the perineum at birth. As I have already said, we must admit the predominance of lacerations in our cases, and yet, the salient duty of every physician at each and every delivery is to exert the utmost skill in preventing a laceration. Next to this, where laceration is inevitable, it is his duty to prevent an extensive degree or type. It is because of the exercise of such skill and carefulness to-day that we can, every one of us, point with pride to our modern obstetrics in diminishing very materially the number of complete lacerations of the perineum,—the horror of every woman. The causes for lacerations at birth, in general, we can thus enumerate:

1. Rigidity of perineum, as found in young and elderly primipara, and in cases with extensive scar tissues from previous injuries.
2. Faulty mechanism.
3. Hasty delivery.
4. Oversize of presenting part, chiefly in reference to the head.
5. Obstetrical operations.—mainly the use of the forceps: and, in mentioning the latter, I cannot help but reiterate a healthful, emphatic condemnation upon the nefarious and unjustifiable practice of using forceps promiscuously and indiscriminately without positive, absolute indication,—no thought, no heed being given to the dangers and risks to the child as

well as to the mother; in the latter, for example, no thought of the increased frequency and degree of injury to the birth canal, resulting so often in untold misery if not complete invalidism.

To conserve the perineum at birth, on the other hand, let us mark the following points:

1. Ample time for dilatation and expansion. I believe harm is done where the fingers are used to stretch the perineal tissues. In the majority of cases where practiced, if but a little more time was given, the presenting part would accomplish all the stretching necessary, and with decided less bruising and subcuticular tearing. Where a rigid perineum is the cause of delayed labor, there being no uterine inertia manifest, I would always prefer the much disputed episiotomy to such manoeuvre. I am not considering here, of course, the value of manual dilatation of a perineum, preliminary to some accouchement force.

2. Secure and maintain normal mechanism. I wish I might be able to go into this one point in detail.

3. Delivery in the side position,—usually the left lateral, and this I recommend in every spontaneous birth, except breech presentations, without distinction of primipara or multipara. I would emphasize care in not flexing the limbs to a degree as to make tension on the perineum.

4. Delivery between "pains," when then, involuntary spasticity of the perineal structures will be absent; as a rule, after the labor pain relaxes which, in vertex cases, brings the anterior fontanelle palpable at the posterior margin of the distended vulva, the head will easily slip out, assisted at least by only a very little effort of the mother, the perineum slipping gradually over the face of the child. And right here I would say, do not make pressure upon the perineum with the free hand, or any manoeuvre which you may think tends to relax the hyper-stretched margin of the vulva; again, do not, as the head escapes, slip or push the perineal tissues down over the face of the child; let it alone,—to follow its own course of expansion and then, retraction.

Yes, to the query some of you doubtless have, I believe in the use of an anaesthetic in cases of perineal rigidity and in cases of precipitate labor. I do not use any anaesthetic routinely.

Then, care must be observed in delivering the second part of

the foetal ovoid, the same rigid care in relation to the perineum. In head-first cases the shoulders must be delivered most carefully to prevent injury, and we should always endeavor to carry the born head up between the maternal thighs, so to impinge the anterior shoulder beneath the symphysis pubis, delivering then, the posterior one first. In this way we have to deal with the smallest shoulder diameter, the cervico-acromial, instead of the longest, the bisacromial.

I would call attention to the evidences of imminent perineal laceration, namely, the anemic appearance of the fourchette, or posterior margin of the distended vulva, and a hyper-glossed or overstretched appearance of the integument of the posterior segment of the pelvic floor. These being present, there are some who practice and recommend the episiotomy. Its value is questionable, however, inasmuch as we have evidences of imminent perineal rupture only and not positive rupture. Except in some cases of perineal rigidity, particularly where forceps are to be used, we would not think of doing an episiotomy without the signs of threatening tear; we wait on these, and then, as so frequently happens, we have a median laceration despite the episiotomy. Where episiotomy is practiced, care should be observed to cut deep enough to sever the constrictor muscle of the outlet and not simply the muco-cutaneous juncture.

It is easy enough to diagnose a perineal laceration immediately after delivery. All we need is a good light and the eye of a conscientious physician. Do not be satisfied and misled by viewing the external skin surface, but with hands properly clean, separate the vulva widely and so expose the vaginal walls as well as the perineum. It is not infrequent to meet with a tear involving the posterior vaginal wall and perineal body, and, at times, as I have seen, the anterior rectal wall, without a scratch or abrasion upon the skin surface, the fourchette being intact. Such a laceration can give rise to serious after results if neglected. Ordinarily, however, the perineal surface will show a certain amount of injury; it may be only superficial, or it may be deep, involving the entire perineum. Ordinarily, associated with the external laceration, the posterior vaginal wall will be involved to a variable degree, beginning at the mid-point at the fourchette and running upward in the median line until it meets with the resistance of the posterior tendinous raphe from whence it is deflected to one or both



sides as the case may be. At times, we find the lateral vaginal fornix involved, the laceration so extending directly into the folds of the broad ligament. To classify the types of lacerations we need mention only then, degrees of extension. In a general way the following captions will hold:

1. Incomplete lacerations:

(a) Superficial,—integumentary or muco-cutaneous.

(b) Deep,—variable degree, involving all types exclusive of tears of sphincter ani and rectum.

(1) A subdivision, embracing complications such as injury to bladder, urethra, labia minora, clitoris, broad ligaments, peritoneum circular detachment of cervix.

(c) Central perineal laceration,— the presenting part being “pushed through” the perineal body between rectum and posterior margin of vulvar outlet. A rare type, most frequently seen in spontaneous delivery of occiput posterior, in hollow of sacrum, with well flexed head.

2. Complete lacerations: Where sphincter ani muscle and rectum are involved.

Attenuations of pelvic floor structures, or sub-cuticular lacerations should be properly included in a general classification of perineal injuries. I am, however, purposely limiting myself to visible solution of continuity.

The after effects of neglected perineal lacerations, or where lacerations are improperly repaired, or after repair sloughing occurs, are many and familiar to us all,—cystocele, rectocele, true and not simple hypertrophies of relaxed vaginal walls, vaginal enterocele, misplacements of uterus in general, with associated hyperemia, hypertrophies and varicosities of neighboring structures.

This brings me to the consideration of treatment, of repair: and right here we are forced into the time-honored discussion as to the time for suturing the freshly lacerated area.—shall it be immediately after the completion of labor or shall we wait twelve, twenty-four hours, or even longer? We constantly meet numerous advocates of both procedures, the greater portion of clinicians, however, readily agree that the time par excellence is immediate, as soon as labor is completed, or in some cases where placental separation is retarded, while waiting for the third stage of labor. And there is no question

in my mind that every item speaks in favor of this immediate suturing. We hear it said, there is too much edema present to place sutures to the best advantage at this time. In cases I have met, where edema is excessive after birth, at the expiration of twenty-four hours we still have the same disadvantage together with, however, a more bruised appearance of the lacerated surfaces and frequently some exudate, necessitating the secondary suture at a later period. Where there is any swelling of the tissues *do not pull your sutures tight*, and the results will be good. In fact, it ought to be a positive rule in the repair of every fresh case, to place the suture tight enough *only* to nicely approximate the surfaces, without making tension on them. And, again, in suturing immediately we gain the distinct advantages of not requiring an anaesthetic in the vast majority of cases; we seal over raw surfaces and so secure prophylaxis against local infections; we disturb our patient when she is willing to submit to a little further pain and annoyance, to be through with everything rather than at the end of twelve or twenty-four hours to have to go through something more, just at the time when she feels the need of rest and quiet and ought to have the same. Where we wait a day or so a general anaesthetic must invariably be used, the partial anaesthesia of the tissues incident upon the birth being by that time gone. Where we suture immediately our duty and obligation to a case is completed, there is no chance for the folly of procrastination, or loss of an advantage to restore the birth canal to normal. Of course, would I again answer to the probable silent query, I admit the exceptional case where hemorrhage, shock, maternal exhaustion, does not warrant us in making immediate necessary repairs.

Then, a word upon technique;—and here I would say, absolute perfect care as to asepsis and antisepsis in detail is to be constantly observed if you are to obtain primary union; and, incidentally, if you do not expect to secure such a result, do not attempt to suture. This applies to the physician first, and then to the nurse upon whom rests the after treatment. Suturing a laceration with improperly cleansed hands, with improperly sterilized instruments and without proper control of the field of operation, without the proper inspection, then, is absolutely inexcusable and criminal, and I make no exceptions of environments having personally been through the worst imaginable.

What a fallacy it is, for example, to attempt to suture with a patient lying on the bed in the ordinary dorsal position, on a bed pan. It takes but a moment to have hands and instruments prepared, to bring the patient's hips to the side of the bed (it is not necessary to have half a dozen people to hold the legs either) when you can see where and how to apply the sutures. With due care in not touching the surroundings, the ideal sterile leg coverings or towels can be easily dispensed with. With due care and the proper application of sutures, primary union ought always to be secured, provided, as I have above intimated, the nurse knows her obligations and is conscientious.

No one method of repair suitable in every case can we lay down; each case must be studied, the degree and extent of laceration noted and the repair to be performed so as to secure normal anatomical relations. There are some general principles I would like to mention to be followed. Let me digress for a moment, however, to cite the folly of a practice we hear of from time to time where the physician puts in a "stitch" of some kind or other and draws the surfaces together, one all-sufficient except in very extensive lacerations when he may be compelled to use as many as two stitches; and when this is done, he turns to his patient with pride, stating the number of sutures. I cannot help but marvel at the skill of such physicians. But to return,—in every laceration of the incomplete type our first duty should be to seek the uppermost end of the torn surface, and here should then be placed our first suture. This prevents drainage of discharges beneath the line of repair, which if allowed, will undermine and produce sloughing. How deep each suture is to be carried depends solely upon the depth of the surface lacerated; deep enough always to take in the underlying tissue so as to prevent "dead spaces." Care not to puncture or injure the rectum necessarily always holds. And, I would urge taking a generous "hold" through mucosa and skin, not simply introducing the suture at the margin of the torn surface. Then again, as already stated, it must be our endeavor to repair the surface anatomically correct, to bring the parts together which belong together; and the eye and finger will be the guides to follow. Beginning then, at the uppermost end of the vaginal laceration, we suture so as to restore the vaginal wall to its normal contour down to the fourchette. For this I prefer a continu-



ous cat gut suture (No. 2 chromocized). This leaves the actual perineal wound, the most important part, in so far as support goes. Do not simply bring skin margin to skin margin,—that looks nice and neat, but does no good. We want always to bring the separated muscular surfaces into approximation in order to give a good, firm perineal body. Frequently we find the divided muscle well retracted behind the skin margin; be on the outlook for this and then introduce each suture in such a way as to include the entire thickness of muscle on one side, pick up enough tissue at the base to avoid leaving a space, and then, the musculature of opposite side, and so when this suture is tied, muscle as well as skin will be in proper juxtaposition. In this way only will we restore the normal integrity of the perineum. Interrupted sutures are always to be preferred for this portion of the operation. Use sufficient number of sutures to give the proper coaptation, and do not stop to count them.

Likewise, lacerations about the anterior vaginal wall, labia minora, clitoris, etc., are to be sought for, and if at all extensive, especially if they are bleeding, should be sutured. There frequently is present one or more small superficial abrasions not oozing, and these are best treated by cauterizing with tincture of iodine. On the other hand, let me say a word about the laceration extending into the vaginal fornix involving the broad ligament, from which almost invariably we have marked hemorrhage. As a rule there is associated a deep cervical tear, involving the cervico-vaginal artery, hence the bleeding. In some few cases we may be compelled to apply a ligature to control hemorrhage; in the majority of such cases, however, it is far simpler, easier, quicker and safer to make a tight gauze pack, and consider the case one of the exceptions and wait twenty-four hours to make our repair. At times we are compelled to wait longer.

In the complete lacerations the same rules hold good, the same principles are to be followed as given, after we have picked up the torn and retracted ends of the sphincter muscle and secured them with a fine chromicized or silk buried ligature, reinforced by external silk-worm gut sutures, and after any accompanying tear of the anterior rectal wall has been closed by a buried line of fine interrupted sutures, tucking in the edges of the mucosa, or if not extensive, freeing sufficient of the rectum so as to allow us to pull down to sphincter margin

the torn portion. I believe these methods better than suturing "intra-rectum" and bringing the ends of the stitches out through the anus. I believe, also, in our after-treatment of these cases we secure better results by locking up the bowels for a week, using the opium and belladonna suppositories.

I should like to advocate and indorse, from personal experience, what I term the "immediate secondary repair" of the perineum, referred to by Hirst as the "intermediate" operation. It applies to the cases where we are compelled to wait for repair, after birth, and to those where we are unfortunate enough in having our stitches slough. It has been generally advocated for these, to let them go for weeks, months or longer, and then do the usual plastic operation. But I am convinced that we do wrong in so advising, to let women get up and about with an unsupporting perineum and go for months in this condition, with its predisposition to all manner of pelvic abnormalities, necessitating frequently, something much more radical than a simple perineorrhaphy to restore them to health. We should always give them the benefit of an immediate secondary operation, before they are out of bed and as soon as we secure a healthy granulating area. It is then easy to curette away such granulations, freshen the torn surface and repair according to our principles. Let us admit we cannot hope to secure the proportion of union as in the immediate primary operation, but so uniformly successful have been my results in both the incomplete and complete types of lacerations, that I most heartily endorse the attempt, and recommend it, rather than to see patients under my care go for months with no pelvic support, knowing the disastrous consequences to which they are thus predisposed. My conscience is abated a trifle after giving them the benefit of the doubt, even though in some cases it may not be successful.

## THE THERMOCAUTERY TREATMENT OF INOPERABLE CARCINOMA CERVICIS UTERI, AND ITS RESULTS.

BY

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(Read before the Germantown Homœopathic Medical Society.)

WHEN the diagnosis of cancer of the uterus is established, the prognosis of the case has almost universally been regarded as hopeless; and the sad experience in most cases has amply justified this view. The vast amount of laboratory research and the difficult and intricate biological studies of malignant growths have added greatly to our knowledge of the histological anatomy of these diseases and of their life history, but have not made available very much for materially influencing the course of a given case. The splendidly organized efforts for the intimate study of cancer must excite our admiration, and increase the hope, indeed the probability, that we are now upon the eve of great revelations that will place within our hands the weapons wherewith successfully to combat this dreadful scourge of our race. But in the meanwhile we are compelled to go along clinically in the old way, holding fast to the theory that malignant diseases are at one time local manifestations, and insisting not only upon early histological diagnosis and extensive early operation, but also upon wide publicity of the early signs, so that gradually cases will be more frequently brought early for operation before the three cardinal symptoms shall exist, which were formerly taught to be diagnostic of the disease, but which we now know are only diagnostic of a fatal case. For some time to come it is likely that cases will be brought to the operator only after the disease has far advanced and then the question presenting will concern the best method of operating, dependent upon the usual indications which call for the various operations together with their contraindications. If the conditions present are unfavorable for operation, the outlook is dark indeed, and it then becomes a question whether it is not far preferable to take a desperate chance by operating, rather than to have the patient and all concerned overshadowed and tortured by the lingering certainty of the ultimate outcome without a single chance. We must ever remember that in these cases there have been some marvelous



results achieved, so that to operate in these cases does not alone hold out the hope of prolonging life for variously long periods so that the operation was worth while and the exitus less distressing, but some seemingly fatal cases have been practically cured, as we ordinarily understand the term.

For a number of years past there have been multiplying in the literature accounts of just such results, namely, unexpected favorable results, in cases which at the time seemed hopeless, or cases in which at the time of operation it was found impossible to remove the entire mass of cancerous involvement, and contrary to all expectation the patients have either greatly improved in health and have died of some intercurrent disease, or have remained practically cured. Close study of cancer cases has shown that the results of operation, even of operation under the conditions just named, have been much better than one would ordinarily believe from experience limited to only those cases coming under immediate personal observation; and of course, it cannot be denied that from simple escarotic treatment, even in the hands of those not of the medical profession, results have been attained which in a measure are satisfactory. Such occurrences have added some data to the life history of malignant diseases and cannot be ignored in their study.

I hope it is quite unnecessary for me to state in so many words that I am in fullest accord with the doctrine of earliest possible and most extensive operation in malignant diseases. But, unfortunately, we too often find ourselves in the position of not being able to carry out this teaching, and then we are compelled to meet the difficult exigencies of the case. Or shall we assent to the view, often based upon some single observation, that cases who have passed this early stage are best left unoperated and practically untreated? In whatever way we may be inclined to meet these difficult problems, it is a fact that many cases, especially in gynecological practice, only seek relief after the disease has attained material headway, and this condition is reached in a period of time appalling because of its brevity. So rapid is the destructive course of cancer of the uterus that one-third of all cases coming for operation are already inoperable no matter when they do come for operation. At Zweifel's clinic, Aulhern (*Arch. f. Gyn.* Vol. 92-1-246) found that in all of the inoperable cases more than three months had elapsed since the first hemorrhage. Not one-third of all the cases came before the end of the first three months. His

table, classified by months, shows that 27.9 per cent. allow four to six months to elapse before seeking medical aid, and this is the largest number coming in any two months. From this it becomes obvious that to possess a means of treatment giving any promise of help to a large number of cancer cases is a desideratum of tremendous import and involves a most urgent duty upon our part. At present we must speak of such treatment as palliative, but if, on examination, we find that such palliative treatment has proven curative, how vastly much better it is! How greatly the value of effective palliative treatment is enhanced becomes obvious when we consider that ordinary surgical procedures are more or less helpless when recurrence has taken place, although we must not overlook the fact that after repeated removal of local recurrences, even four or five times, some cases have ultimately remained well. But many have unfortunately been left to themselves without treatment, while the ever-recurring reports of good results from the treatment under consideration are making an insistent appeal for its recognition, and some consideration of the scattered data makes the conviction almost unescapable that if the value of this treatment were more widely recognized, it might be applied with the greatest advantage and some patients thereby saved. It has been truly said that those who are under the dominion of radicalism in surgery can see no good in any other method and will remain skeptical of this; and the same will probably be true of those who apparently must have the life processes of all conditions now recognized as surgical conform to those of one or more such processes; particularly will it be true of a method whose highest claims are but the modest ones of palliation. At best every remedy or procedure advocated for use in malignant diseases has a difficult task to establish recognition. Theilhaber (*Zentralbl. f. Gyn.* 1911-4-355) concedes it seems absurd to suppose that partial extirpation would give better results than the radical operation. And yet there are several reasons which also theoretically speak for the isolated extirpation of the cervix. He quotes Hofmeier's report, 1878 to 1886, from Schröder's clinic of having had 40 per cent. cures four years after partial extirpation. After thirty-three total extirpations not one was living four years after operation. Winter continued this report subsequent to 1886 and mentions 26½ per cent. permanently cured eleven years later.

The time has surely come for us to take note of the large

number of cases rapidly accumulating, wherein unexpectedly favorable results have followed presumably incomplete removal, especially when combined with the actual cautery treatment. Such results were not observed in isolated instances and they were not accidental. Let us remember, as has been tersely said, there are no accidents in Nature.

Purposely omitting at present the technical details, it may be said that the treatment employed in the cases about to be mentioned consisted in the surgical removal of the larger mass of the malignant growth and the thorough application of the thermo-cautery to the area exposed and to the site of the irremovable, apparently malignant involvement. In some instances the cautery snare has been used to remove the larger mass, and the thermocautery used as just indicated. Let us bear in mind that the cases about to be mentioned are reported by physicians well known in the medical world; and that they occurred in the midst of large series of cases in which the majority pursued the dismal course; but the unexpected results should, for all that, fix attention upon a method not sufficiently regarded in our operations, and not often enough considered by men in general practice who may still retain such cases under non-operative treatment destined to have but one fatal termination.

In order to judge the results of certain methods of treatment it is obviously necessary that we know the usual course of the disease unaffected by any treatment, and at least to glance at the results of other methods of treatment with which comparison is to be made. For such purpose we must look to the records of series of cases, and preferably to such as have been treated by one man or under his guidance at one clinic. There are several records of this sort available, and almost any one would serve the purpose, but the cases treated at Martin's clinic will be used (*Lick: Monatsschr. f. Geb. u. Gyn.* Vol. 20-2-227). During the five years preceding 1904, 2,724 cases of all sorts were treated; of these 165, or 6 per cent., were affected by carcinoma of the uterus, excluding recurrences after former operations. Of these cancer cases 95, or 57.6 per cent. were subjected to radical operation; 70, or 42.4 per cent., were inoperable. Upon these 70 cases our attention should be fixed. It was found that the time allowed to elapse from the very first onset of symptoms of ill health until the patient sought relief at the clinic varied from one month to two



years at longest, with an average of  $6\frac{1}{2}$  months. So we may say that these 70 patients usually allowed  $6\frac{1}{2}$  months to pass before seeking medical aid. From this it must not be assumed that the course of the disease was regular, for in eight cases who sought relief two months after the first symptoms, the disease had advanced beyond the stage admitting operative intervention. It may be of interest to note that in 21 cases the first symptom was sudden hemorrhage, 13 had offensive discharge, and three had pain, while the remainder had combinations of these three symptoms; all usually had loss of appetite, loss of weight and weakness.

After electrolysis, zinc chlorid and other methods had been used with poor success in previous cases, 60 of the 70 cases which we are studying were treated by curettement and cauterization, with one death. The usual results observed after this treatment were disappearance of necrosis, cessation of hemorrhage and sometimes of the pains. The removal of offensive odor permitted the appetite to return, and with it an increase in strength and general well being. The patients usually left the hospital in about two weeks, at which time examination showed the infiltrated parametrium still unchanged, and instead of a necrotic crater a smooth wound cavity with granulating walls remained. This good condition was, of course, but transient.

Later information was available concerning 59 of the 60 cases, and showed that 48 died within one year; 9 lived six months longer, and two lived  $23\frac{1}{2}$  months and 54 months; the average time being 228 days, or 7 6-10 months after leaving the hospital when death occurred. This time corresponds very nearly with that observed in other statistics; namely, Gebauer, 229 days; Eyring, 224 days; Berton, 281 days, and Blau, 252 days. We may say that from the first appearance of symptoms of carcinoma uteri the case terminates fatally in 14 months as an average time.

On the other hand, it is interesting to note that if the patients treated by curettement and the cautery be considered in a class by themselves that their average life was 259 days, instead of 228 days, the average of all the cases. Most of the cases after leaving the hospital did not return when recurrence appeared, but in three instances the patients did return and the operation was repeated. The first case was operated twice and lived 305 days; the second case was operated three times

and lived 707 days; the third case was operated twice and lived 535 days. In these cases, therefore, the duration of life was 305, 707, and 535 days as compared with 228 days, the average of all the cancer cases.

Similar observations have been made elsewhere. Thus, of a series of cases operated by Gebauer two patients lived for 4 and  $4\frac{1}{2}$  years; Berton, one case 820 days; Eyring, one case 1,083 days; Blau (*Chrobak's Festschr.*, page 591; Wien, 1903) reporting 408 cases from Chrobak's clinic, found among them one case living 10 years after operation; 4 living between 3 and 4 years after operation; 22 living 3 years after operation. In 7 cases death ensued in from 3 to 6 years; one case died in 10 years, and one case in 11 years after the operation. Here we have recorded a marvelous result of treatment of a fatal disease existing in an inoperable condition.

It was the multiplication of such cases which led Lomer (*Zeitschr. f. Geb. u. Gyn.* Vol. 50-2-305) to collect these cases for study and comparison. Thus he showed that Pawlik in reporting 136 cases from Braun's clinic, found among them 29 cases who were free from recurrence during periods of time varying from 2 to 20 years. These cases had all been followed up by Pawlik when he reported them, and in every instance the diagnosis had been confirmed previously by microscopic examination. v. Grunwald had two cases living 5 and 10 years without recurrence. He emphasized the importance of repeated cauterization. In one case he cauterized five times and the patient remained well for twelve years. Schultze-Vellinghausen reviewed the cases reported by Sanger and found among them five cases free from recurrence from  $1\frac{1}{4}$  to  $3\frac{1}{2}$  years. Klotz cauterized his cases every ten days, and in six instances they remained well for 4, 3, 2 and  $1\frac{1}{2}$  years. Lomer subsequently inquired about these cases and found one died five years after operation, the remaining five being quite well. Frankel reported three inoperable cases treated, who remained well  $5\frac{1}{2}$ , 4 and  $2\frac{1}{2}$  years. Schroder mentions one case free eight years after cauterization. Hofmeier found, in 71 cases treated, no recurrence in from 2 to 18 years. Veit had one case well four years later. Machenrodt said we must learn to extirpate the uterus entirely with the cautery since no method can compare in results with it. He reported 18 cases operated without recurrence from  $3\frac{1}{2}$  to  $6\frac{1}{4}$  years after. Jordan cites a case too far advanced for

radical operation and the diagnosis confirmed by microscopic examination. The case was treated with the cautery. For two years the patient remained well, when atypical hemorrhages and inflammation in the abdomen necessitated six weeks' confinement in bed. Laparotomy and removal of the adnexal inflammatory mass together with the uterus and portio vaginalis showed on microscopic examination not the slightest trace of cancer. Chrobak reported 45 unselected cases treated with the cautery. Two years later 68.4 per cent. were still well. Of the cases operated before and after these cases, using the knife alone, 50 per cent. remained well after two years. Labbe refers to a case free after 10 years, and Pomard to a case well  $2\frac{1}{2}$  years later. Gallard cites a case absolutely inoperable in whom after the fourth cauterization at twenty day intervals the improvement was so great that the case was scarcely recognizable as the originally inoperable patient. He reported other cases well up to four years. Nairne treated an inoperable case with the cautery who remained well  $3\frac{1}{2}$  years. Madden prolonged the life of 22 cases for  $2\frac{1}{2}$  years at shortest. Baker treated 10 cases, among whom five remained well from 10 to 12 years; and in another series of 16 cases, ten were well from 2 to 8 years. Cushing has seen freedom from recurrence from 3 to 5 years after this treatment. Among 55 cases treated by Reamy, 20 were well from 2 to 8 years. Williams saw cases well after 8 or 9 years, and Spencer Wells 5 to 6 years. In America, Byrne has given much attention to this treatment and first published his results in 1889. (*Trans. Amer. Gyn. Soc.* Vol. XIV-91; and *Brooklyn Med. Jr.*, 1892. Vol. VI-746). It seems remarkable that his reports attracted so little attention. In looking for an explanation it may possibly be found in that these results were cited as competing with those of vaginal hysterectomy—and operators had not yet expended their ingenuity in perfecting this operation, so that at the time his method seemed to be rather a retrograde step. Since, however, both vaginal and abdominal hysterectomy have had opportunity for demonstrating results it seems not unlikely that Byrne's reports will again receive attention and his forceful advocacy appear justifiable rather than hyperenthusiastic. Without going into detail, we may select from his reports 40 cases affecting the portio vaginalis out of 63 treated in whom he could trace exemption varying from 2 to 22 years, and averaging for each one over nine years. Of 81 cases affecting the



entire cervix in 40 there was an average of exemption for each one of nearly six years. Lomer recites a number of cases treated by himself and gives the results, which need not be recounted. In addition to these cases Weindler (*Zentralbl. f. Gyn.* 1907-22-632) reports three typical cases of cancer of the cervix. One was living seven years after treatment when reported, and had no recurrence; and the other two lived six years after.

Many more such cases could be cited, and can readily be found by anyone making the search. It is, however, unnecessary to multiply instances; sufficient have been mentioned for the present purpose. But in order to recount at least one case of recent date, there is the one by Bretschneider (*Arch. f. Gyn.* Vol 92-1-107) published in 1910, concerning a cachectic woman, aged 53 years, having glandular carcinoma of the cervix in a far advanced stage of the disease, who was treated by ex-cochleation, cautery and zinc chlorid. About seven months later it became necessary to repeat the operation. In about four months she reappeared at the clinic. At this time she had lost the cachectic appearance, the cervix was found smooth, somewhat nodular and at the external os some cancerous degenerating tissue protruded. Since the uterus was at this time found to be more freely movable, the abdomen was opened for the purpose of operating radically. The peritoneum and pelvic glands being found cancerous, later confirmed by microscopic examination, the abdomen was closed and the cervix treated as before. About a year later the patient was practically well and was exhibited at a Society meeting on June 26th, 1910, which was about two years after the first operation. This author, like most others whose cases are reviewed above, is not swept away by enthusiasm, but expressly states it is not to be assumed that this patient is fully free from cancer foci; but rather is it likely that in her body many cancer foci still exist, but in the course of time they have lost their power of proliferation; the foci have become latent, as occurs in tuberculosis.

Having now referred to such a large number of cases the temptation arises to review some of the opinions of operators whereby it has been attempted to explain occurrences so opposed to frequent experience, to current teaching and to commonly accepted belief. But I shall omit all this sort of thing.

and simply refer to some of the facts which have lately been pointed out concerning cancer.

Foremost is the matter of spontaneous healing in certain malignant cases. Gaylord and Cowes (*Surg. Gyn. and Obs.* Vol. 2-633), in writing on this subject, say that of the many cases reported, but few will withstand critical analysis. Most are inflammatory lesions, syphilis, Hodgkin's disease, etc., which are confused with sarcoma. But they seem to be satisfied concerning 14 authentic cases having malignant disease in various parts of the body. In mice, however, they have no doubt at all of having seen 100 cases spontaneously recover. Indeed, they have found this to be the rule in 23 per cent of experimentally inoculated mice. They say also that the frequency of and distribution in animals suggests that it may be more frequent in human beings than is generally supposed. Sticker (*Zeitschr. f. Krebsforsch.* Vol. 7-55) has also shown that spontaneous healing occurs in animals.

It has long been taught that the smallest fragment of tissue histologically having malignant character is capable of reproducing the disease in loco and its cells have the power of unlimited multiplication. While we must concede the existence of this potentiality, it does not always manifest itself in fact. This phenomenon is not explainable at present, but the observation has a most practical significance as indicating that the disease should be most actively combatted until the very last, since it is impossible to know beforehand what will be the ultimate outcome in a given case. Almost every published series of cases contains some who were repeatedly operated and ultimately cured, provided the active therapie was repeated upon the slightest appearance of recurrence.

That we are not so helpless in the treatment of cancer as was once thought is also shown by the results of operations wherein surely the entire cancerous involvement was not completely removed. This is not only true in gynecological cases, but is especially noteworthy in cancer of other viscera, particularly of the stomach. Under certain conditions it seems that when the major focus is removed the system possesses powers of defense which in some instances are able successfully to cope with the smaller parts remaining. This seems to be especially true when a greatly impaired vital function is restored as after resection, or even after simple gastro-enterostomy, in cancer of the stomach. In some such way can probably be explained

Czerney's twelve cases of cancer of the stomach, reported in 1907, who had unexpected healing after gastro-enterostomy, some of whom lived fourteen years after; Mayo's 27 per cent. alive over three years after resection of the stomach; Miculicz's 16 per cent. alive over three years, and Kronlein's cases living after three years, and Kocher's after fifteen years.

Intimately associated herewith is the fact that enlarged and probably cancerous glands are often necessarily left behind in many operations. This is doubtless true in abdominal operations above the pelvis and it is just the results in cases having the disease located here, which have recently given so great encouragement in our battle with malignant diseases. But in pelvic cancer the study of the lymph glands has received much attention, notably on the part of Kroemer (*Arch. f. Gyn.* Vol. 73-1-57), Pankow (*Arch. f. Gyn.* Vol. 76-2-337), Fromme (*Arch. f. Gyn.* Vol. 79-1-261), Stickel (*Arch. f. Gyn.* Vol. 90-2-395) and many others. It is obviously impossible to review the results of these great investigations, but a few facts might be mentioned. Thus, Kroemer has shown that uterine cancer usually spreads by continuity and as a rule the regional glands are not early affected. Pankow has made the same observation that carcinomatous glands are usually found in far advanced cases, rarely in the beginning. It is not possible to determine macroscopically from the size and consistency of the gland, whether or not it is cancerous. The parametrial glands frequently first become diseased and may be so affected while the parametria and regional glands are still free.

Fromme's studies have shown that bacterial invasion, which has passed the cancer to the glands, may secondarily bring about the formation of granulation tissue, and later of connective tissue. The latter may be produced by the cancer itself. This is really an effort at healing, since the glands, not yet cancerous, may offer a greater resistance to the entrance of cancer. In cancerous glands the cancer may, by being encapsuled by connective tissue, gradually disintegrate and die. Thus arise the glands filled with white smeary masses. On account of observations of this sort, Clarke (*Surg. Gyn. and Obs.* Vol. 2-146) has been led to abandon the extensive search for the glands and their removal in his abdominal hysterectomy operation. He says the prolongation of the radical operation and the high mortality from it is not justifiable under the circumstances. Cullen also found the glands not often involved or



very rarely before the disease has advanced so far that the case has become inoperable. Winter is also quoted as having only twice found cancerous glands in 44 autopsies where the disease was still confined to the uterus; and Werder has returned to the cautery and high amputation as suggested by Byrne. In regard to recurrence also we must modify some of our views, since both Stickel and Sitzenfrey (*Zeitschr. f. Geb. n. Gyn.* Vol. 69-106) have shown that enlarged glands, thought to contain recurrent cancer, may not be cancerous at all.

Summary: The main points made in the foregoing paper are that records are accumulating of a large number of cases of carcinoma of the cervix, amounting to hundreds of cases, in which for various reasons, mainly because of the advanced stage, the neoplasm could not be radically operated, but the operators had to content themselves with the removal of the larger part, and then they energetically and repeatedly applied the actual cautery. Contrary to all expectation many of these cases have remained well for a surprisingly long term of years. The operation is not attended by a high mortality, while it materially improves the general condition of the patient, and very often relieves the pain. Moreover, many cases are recorded in whom after this treatment, the lateral involvement has so far disappeared as to make the radical operation not only possible, but successful. In view of these good results, which occur with a frequency entirely unrecognized by many physicians, the actual cautery treatment should be much more frequently applied; and because these results have been so successful the treatment may well be considered as competing with the radical operation. Since carcinoma of the cervix is so rapid in its progress that when many patients present themselves, a large number of them have already passed beyond the time for the radical operation, the cautery treatment should then be persistently used and repeated. This treatment is particularly called for and may still succeed when recurrences entirely preclude radical surgical intervention.

**SOME VAGUE LIVER DISEASES.**

BY

C. H. SMITH, M. D.

(Read before the Goodno Homœopathic Medical Society.)

DR. WOODS HUTCHINSON, in a lengthy article in one of the popular magazines makes a startling statement concerning the importance of the liver. To the condition of one's liver he attributes all the success and failure, the power of invention, the ability to make money, in fact, the things we do are done in accordance with the condition of our livers. Whether this be true or not I will leave to personal opinion.

It is not my wish in writing this paper to give any new information in liver conditions, but to present two cases which I have treated lately, and if I can present them in such a form as to start a discussion, will feel that my work has been well done. The correct diagnosis of some liver conditions is extremely puzzling and our methods of diagnosis, according to the present day facilities, are not very exact.

Taking up the objective symptoms, inspection demands full exposure of the region of the liver and the whole abdomen. The usefulness of inspection as a means of diagnosis is very limited, but if advantage is taken of all the possible information it affords, its practice will occasionally add greatly to the knowledge at hand. First, any undue prominence or absence of the same is to be noted. Hepatic enlargements visible to the eye are very rare in adults. In children such enlargements are frequently visible, due to the greater elasticity of the chest walls. When the liver is considerably enlarged and the abdominal wall is thin, it may be possible to observe the lower margin of the liver rising and falling with each respiratory movement. Tumors below the costal margin of the liver are, of course, readily recognized. One other point under inspection, the enlarged superficial veins of the abdomen wall are frequently seen when the liver disease has interfered with the portal circulation.

Second, palpation as a means of diagnosis is useful only in the cases where the liver is enlarged. In the healthy subject the liver is not palpable below the costal margin. Probably the best method to be used in palpating the liver is to have the pa-

tient in a reclining position with the head and shoulders slightly raised and the knees flexed upon the abdomen. See that the abdomen wall is relaxed. The tips of the palmar surface should be pressed firmly inward below the margins of the ribs during or at the end of expiration. In this way it is possible to get the fingers well beneath the ribs, so that when inspiration takes place the liver is forced downward and its lower edge is felt to glide beneath the examining finger.

The character of the surface is given by various authorities as being readily felt by palpation. It has been my experience that unless the alterations are very great or the abdominal wall very thin, it is impossible to gain any information as to the character of the surface.

The gall-bladder cannot be palpated in the healthy subject as a general rule. When, however, the gall-bladder is greatly distended and the walls unusually thin, it may be felt as a smooth, round, fluctuating tumor. The position of the gall-bladder is immediately beneath that point at which a line drawn from the right acromion process to the umbilicus crosses the right costal margin.

Several warnings must be remembered in palpating the liver. With a lower margin of the liver readily palpable we must be sure that the upper margin is not depressed before making a diagnosis of enlarged liver. Tumors behind the liver may push it forward and downward and bring it into undue prominence and fasten our attention on what may be mistaken as an enlarged liver.

Third, percussion. When practising percussion in the examination of the liver it must be borne in mind that there is an area overlapped by lung tissue and here we get relative dullness. Light percussion here gives pulmonary resonance, modified by the existence of the solid organ beneath. Deep percussion gives the dulness of the organ.

For the lower margin various difficulties present themselves. Cabot says, "Unless the lower edge, either sharp or rounded can be felt, one cannot be sure of liver enlargement, for percussion of the lower edge of the liver is notoriously unreliable." Dullness below the costal margin is frequently found in cases without hepatic enlargement and should never be relied upon unless the liver can be felt.

Increased liver dullness is found in all diseases where the liver is enlarged, and arranged in order of frequency include



passive congestion, obstructive jaundice, malignant disease, abscess, syphilis, cholangitis and a few rare conditions. The largest livers are found in malignant disease, biliary cirrhosis and abscess.

Diminished liver dullness may be due to diminution in the size of the liver itself or to the separation of the liver from the abdominal walls by the interposition of the distended stomach or intestines. Atrophic cirrhosis of the liver and acute yellow atrophy of the liver show a diminished size in a small proportion of cases but it is rarely recognized in either condition.

Auscultation is not practical as a means of diagnosis in liver diseases.

Some other points must be taken into consideration in making a diagnosis in liver conditions. The first of these that I will mention are pain and tenderness in the hepatic region. Pain forms little or no part in many cases of liver disease since it occurs only when the capsule is stretched or its nerves are involved in a perihepatitis. Beside this capsule pain, we have pain referred to the right scapula and less often to other parts of the back.

Jaundice as a symptom is very common in liver diseases. While it is true that all jaundice is due ultimately to obstruction in the bile stream, yet jaundice may present itself as a symptom without organic change in the liver; such jaundice as is seen in toxemia, malaria, septicemia and pernicious anaemia. The results of jaundice upon the body are chiefly slow pulse, itching of the skin, mental depression and a hemorrhagic tendency. Jaundice being only a symptom, the diagnosis of the cause depends upon many considerations. Chief among its causes are jaundice of the new-born, catarrh of the bile duct, cancer, gall-stones, cirrhosis and the infections. The infectious group of symptoms such as chill, fever, sweat, disturbance of digestion and sleep, are most frequently seen in cholangitis, hepatic abscess and stone in the common duct.

The cerebral symptoms may be mentioned as coming on in the cirrhotic cases and vary from simple depression or apathy to delirium and coma.

Within the past year or two it has been my fortune or misfortune to meet with several unusual cases of liver disease which I think are worthy of mention.

CASE I. Mrs. R., age 47, mother of seven children, gave a family history of mother and father dying of old age. One

sister died of cirrhosis of liver, one of cancer of gall-bladder. One brother died of some vague liver trouble.

Personal history showed the usual childhood diseases, typhoid fever at the age of 25; general health had been good until six months before I saw patient when there was considerable soreness in the region of the liver, loss of appetite, constipation and considerable vomiting. When I saw the patient the sclera, skin and mucous membranes were stained a yellowish green color with green predominating; there was loss of appetite, subnormal temperature (the temperature never going above 97.4); there was a pus infection in both eyes which gave considerable trouble. The urine showed a high percentage of bile and albumen. Stools alternated between green and a dark putty color. Liver was greatly enlarged, at least three finger breadths below the ribs. Had never had any acute pain in liver. This lady went to Philadelphia to have her eyes treated and while there was operated at the University Hospital for impacted stone in the common duct, but no stone was found and, on the second day following the operation, died of pneumonia. I never made a diagnosis.

CASE 2. Mrs. G., age 54, mother of three children, gives a family history that is rather peculiar. For three generations all members died of apoplexy except one person and he was killed by a train.

Personal History: Had scarlet fever when a child; malaria when forty years old and several attacks of acute articular rheumatism. I saw the case sometime in May, 1910, and found an attack of pain which simulated very closely a case of gall-stone colic. This attack followed the orthodox rule with jaundice, etc., following. Repeated washing of the stool after this attack failed to reveal any stones. During June, 1910, there were nine attacks, but after these attacks of pain, there were symptoms of acute obstruction, and after using high enemas repeatedly, the lady passed some concretions that were of a green-black color, varying in size from a pin head to the size of a lima bean. Within this week of July, 1910, there were passed by the bowels 119 of these concretions. During the past two years there have been probably fifty to seventy-five of these attacks of hepatic colic and to-day my patient is a semi-invalid with a number of complex nervous symptoms, persistent swelling of the feet, liver not enlarged, gall bladder palpable, no jaundice or at least none to a marked

degree. My diagnosis has been inspissated bile concretions. But what causes the concretions?

Treatment: Chionanthus and chelidonium seem to have given most relief from the soreness in the liver. These are not given as a routine measure. Artificial Carlsbad salts in doses of one coffeespoonful in hot water every morning and three grains of sodium salicylate in a glass of Vichy twice a day at irregular intervals.

This patient could not tolerate morphia during the pain on account of severe vomiting following its use, but found that codeine served instead of morphia very well. I hope these rambling remarks will serve to elicit a discussion which may throw some new light on the case.

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### THE USE OF SALVARSAN IN SYPHILIS.

BY

J. M. KENWORTHY, M. D., PHILADELPHIA.

OF the recent contributions which have been given to medicine in the sphere of chemo-therapy, none, perhaps, has attracted more attention than Ehrlich's arsenical preparation known as salvarsan or "606," the use of which in syphilis we are about to discuss.

The usefulness of the remedy depends upon the selective action of arsenic upon the germ of syphilis, the spirochaeta pallida. I may mention in passing that salvarsan has a like effect in recurrent fever, yaws, and it is claimed in malaria.

#### INDICATIONS.

The remedy when first introduced was heralded as the specific which was to cure syphilis in a single dose. That it will not do. Whether it will cure in repeated doses we have yet to learn. But it will promptly and efficiently control and heal the primary and secondary lesions of syphilis, and will arrest further inflammatory changes in tertiary lesions. It is not to be expected that salvarsan will remove the sclerotic changes caused by syphilis.

This, then, in my opinion, is the field of salvarsan at the present day: First, to quickly control the severity of the outbreak and render the patient less infectious. Second, as a re-



serve for any outbreak during the course of treatment. Third, in malignant syphilis where grave lesions or loss of life may result before mercury, even in heroic doses, has time to act.

#### CONTRAINDICATIONS.

We have been warned in the use of salvarsan to watch the heart and the eyes. I have observed little or no effect on pulse rate or tension. If the heart or circulatory system were so badly damaged as to make it unsafe to throw 250 c.c. of fluid into the circulation within twenty minutes, then the intravenous injection of salvarsan would be dangerous. Otherwise, I see no heart contraindication.

Every case injected has had the eyes examined before and one week after the injection. We have had no toxic eye effects. On the contrary, cases of optic neuritis have been benefited.

Advanced degeneration of the central nervous system contraindicates; as does extreme cachexia, not due to syphilis. I should be fearful of using salvarsan if the kidneys were badly damaged. Known idiosyncrasy to arsenic should be taken into account.

We have had no fatalities. There have been some deaths reported, but I believe they have been due to the careless or injudicious use of the remedy.

#### METHODS OF ADMINISTRATION.

There are two methods of administration,—the intramuscular and the intravenous. I prefer and use the intravenous. In the intramuscular, either a neutral suspension, a cloudy alkaline solution, or a clear alkaline solution is used. Probably the cloudy alkaline solution is most used, being better absorbed than the suspension and causing less pain than the clear solution which is more alkaline. The injection is made deep into the gluteal muscles. It causes considerable pain and discomfort and I doubt whether it is always absorbed. I have seen a case, in which the solution remained unabsorbed and had caused a sinus three months after the injection. The patient's syphilis was, moreover, uncontrolled. It would seem to me that, in the use of salvarsan, the spirochaeta should be struck a sudden, hard blow as in the intravenous method. In the intramuscular injection, absorption is, at the best, slow,

giving the spirochaetae time to acquire a partial immunity to the drug, thereby only stunning them.

In the intravenous injection, a clear alkaline solution is injected directly into a vein as in an intravenous infusion. Some operators inject it with a syringe. I have found the gravity method entirely satisfactory. The operation causes practically no pain and in none of our cases have we had an infection or any other trouble at the site of injection.

The solution must be mixed and injected under a strict aseptic technique. Care must be taken to guard against air embolism, and infiltration of surrounding tissues must not take place. If the opening of the needle is not fairly within the lumen of the vein or if the point of the needle has pierced the far wall of the vein the solution will infiltrate the surrounding tissues. The needle must then be withdrawn and another vein selected.

The intravenous method is, perhaps, a little more trouble, but we are amply repaid by the rapid and efficient results.

#### SEQUELLAE.

After the intravenous injection of salvarsan, the patient is better in bed until the next day. Most cases have more or less reaction, consisting of a slight temperature rise (100 to 101 degrees), malaise, a little nausea, sometimes headache; a few vomit; some have no reaction whatever.

#### DOSAGE.

The dose varies with the weight of the patient and the severity of the attack. Women and children usually require less. I almost always give .5 gm. except in case of a child, a small woman or a very small man. A child of say 65 pounds would take 225-250 milligrammes. We reckon .5 gm. to 130 pounds or over of body weight. I believe that when we know salvarsan better we will give larger doses.\*

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\*Since last October Ehrlich has had Schriever of Magdeburg, and others trying out a new preparation of 606 which he calls Neo-Salvarsan. This preparation admits of a dosage almost double our present dosage of salvarsan and it is claimed causes less reaction. Another advantage is that it is soluble in a neutral solution thus doing away with the present tedious process of making the solution.

## AFTER-TREATMENT.

The after-treatment of salvarsan is the routine treatment of syphilis: diet, hygiene, exercise, regular hours, abstinence from alcohol and tobacco, mercury, with two modifications: First, we think the injection saves one year of treatment. Repeated injections may prove to save more. Second, patients who have been injected with salvarsan seem not to have the same toleration for mercury, therefore it is wise to put them on the average dose. I usually prescribe the yellow iodide IX 2 tablets t.i.d. I have, in a number of cases, tried to find the patient's tonic dose after the injection, but have found it unsatisfactory. I start the mercury one week after injection. I might mention that it is wise to stop all medicine one week before injection.

## RESULTS.

I have to report fifty-two cases injected intravenously at the Hahnemann Hospital, all of which have been under my care and observation, and a large number of which I injected myself. I will group them under the various manifestations of syphilis. (See Chart.)

I think you will agree with me that in this series of cases, salvarsan has made good. It has certainly cured lesions much faster than any other method we have at the present time. Whether salvarsan alone will cure syphilis we do not yet know. Most men are following salvarsan with mercury. The men who are trying out neo-salvarsan are giving four intravenous injections at intervals of two days. If, after two weeks, the Wassermann is still positive, then repeat the injections after four weeks under Wassermann control. They are not using mercury.

At the present time, I do not think we are ready to rely upon salvarsan alone; perhaps when we know the remedy better and give larger and more frequent doses we may. Until then use salvarsan when there are symptoms to be controlled, and mercury as routine.



Number of cases, 52.	Number of cases.	Min.	Days in Healing. Max.	Average.
Chancres—				
Of Penis, uncomplicated ..	20	3	27	13
“ “ with phimosi s ..	4	4	10	8
“ “ phagadenic.....	1	Process stopped in 3 days.		
“ “ metal .....	2			11
“ “ intraurethral ..	1			10
“ tonsil .....	2	7	9	8
Rash .....	25			
Improvement noted .....				3
Entirely gone .....				14
Sore throat .....	7	1	5	2½
Mucous patches —				
Of mouth .....	14	3	9	5
Of tongue .....	9	4	9	6
Of tonsils .....	4	5	10	7
Of penis .....	5	3	7	5
Of scrotum .....	3	3	7	5
Aortitis .....	1			5
Iritis .....	3	6	16	9
Episcleritis .....	1			13
Optic Neuritis .....	2	{ (1 case controlled in 7 days) (1 case imp. and relapsed.)		
Orchitis .....	1			
Imp. in 5 days, entirely gone in 6 weeks.				
Osteo-periostitis (Int. Mall Tibia) .....	1	Imp.		
Paronychia of finger.....	1	Rapid healing.		
Gumma of forearm.....	1	Healed.		
Gumma of leg.....	2	(1 healed and 1 imp.)		
Abscess of lung.....	1	Imp.		
Ulcer of back, serpiginous tuberculo-ulcerative 2x2½ in. ....	1	Healed in 18 days.		

CHOREA OF GENITAL ORIGIN.—Bossi (Genoa) has recently found further confirmation for his belief that there is an intimate relationship between gynecological diseases and nervous and psychic disturbances. He reports in detail the history of a married woman, aged 18 years, who developed symptomatic chorea after a premature delivery at seven months with normal puerperium. Two weeks later, however, menorrhagia appeared which ceased in a few days. About a month later she suddenly developed chills, myalgia, and arthralgia for about a week, followed by great weakness and myasthenia. The gynecological lesions found consisted of inflammation of the cervix and infectious endometritis with retroversion. After appropriate treatment for these conditions the patient was cured of her nervous and psychic disturbances with wonderful rapidity.—*Zentralbl. f. Gyn.* 1911-1666.

## EDITORIAL

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### THE COMING MEETING OF THE AMERICAN INSTITUTE OF HOMŒOPATHY.

THE interest of homœopathic physicians throughout the United States is now being centered in the Annual Meeting of the American Institute of Homœopathy which will be held at Pittsburg, Pa., June 16th to 22nd. To the homœopathic practitioners of Pennsylvania this meeting should be of especial interest because of the fact that this is the first session of the Institute that has been held in Pennsylvania for many years, and also because one of our own fellow practitioners, Dr. T. H. Carmichael, of Philadelphia, has been honored by the Institute with the office of President.

The indifference of the homœopathic practitioners of Pennsylvania to the work of our national organization has been unfavorably commented upon by many and a certain amount of this criticism is undoubtedly justifiable. There are some Pennsylvania physicians who are very loyal and very active in their support of the American Institute of Homœopathy; but, during recent years at least, Pennsylvania has never taken the position she should in the Institute as the foremost homœopathic state in the Union.

It is to be hoped that the coming session in Pittsburg will witness a renewal of interest in the work of the national organization on the part of the Pennsylvania homœopaths, and to this end it is important that every practitioner should plan to be in Pittsburgh at least part of the week during which the sessions of the Institute are held.

The Committee of Arrangements in Pittsburgh have been very active in preparing the way for a large and successful meeting.

The sessions of the Institute will be held in Memorial Hall, one of the most beautiful and spacious buildings in Pittsburgh. Not only is there a large auditorium with sufficient seating capacity to provide for every member of the Institute, but there are ample accommodations for the various

bureaus and sectional societies. The hotel accommodations have also been exceptionally well provided for. The Hotel Schenley, one of the leading hotels of Pittsburgh, is directly opposite Memorial Hall, and the Henry, the Seventh Avenue, the Lincoln, and the Annex are within easy access. The chairmen of the various bureaus all report an excellent list of scientific papers. A large proportion of the ablest writers and most experienced practitioners of the homœopathic school are expected to read papers or deliver addresses, and a week spent at the Institute is practically equivalent to a post-graduate course in the various departments of medical science.

All physicians are urged to attend the sessions of the Institute whether they are members or not, but if you are not a member, the Membership Committee will be glad to hear from you at once.

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#### THE ROYAL COMMISSION ON VIVISECTION.

THE report of the Second Royal Commission on Vivisection, which was appointed in 1906 to investigate the subject of animal experimentation in England, has been received with considerable attention throughout the scientific world. The Commission held over seventy meetings and every aspect of the subject, both from the standpoint of the anti-vivisectionists and from the medical standpoint, was fully presented by representatives of the parties concerned. The report is contained in five large volumes and comprises nearly twenty-two thousand questions with answers.

After four years of study and consideration of this vast amount of testimony, the Commission has published its final report. The findings of the Commission are distinctly favorable to the work of the medical investigators, and the recommendations made by them are so insignificant that they will result in practically no change in the present attitude of the law toward vivisection.

Regarding the harrowing stories of useless pain inflicted upon animals, that have frequently been reported by sincere but hysterical opponents of vivisection, the members of the Commission state, "That they have come to the conclusion that witnesses have either misrepresented or inaccurately described the facts of the experiments," and they further add



that "many of these descriptions illustrative of operations inflicted upon animals are calculated to mislead the public."

The section of the report dealing with the results of animal experimentation in advancing medical science, conclusively shows that many of the most important improvements that have been made during the last sixty years have been to a greater or less extent dependent upon animal experimentation.

The moral aspect of the subject of animal experimentation received considerable attention on the part of the Commission. The opponents of vivisection took the ground that under no circumstances was it justifiable to inflict pain upon an animal for the purpose of saving human life. This view was forcibly expressed by one witness who said: "I would not have one mouse painfully vivisected to save the greatest of human beings or the life dearest to me." The Commissioners did not agree with this view, which, in fact, strikes us as being utterly absurd when we realize that many of the advocates of such opinions do not hesitate to encourage the slaughter of birds and animals of all descriptions, sometimes by the most painful methods, for the purpose of decorating their hats or of supplying the demands of their vanity in some other direction. The Commissioners concluded that, as the moral sense of Christian communities was not offended by the sacrifice of the lower animals for food and clothing, experiments on animals, adequately safeguarded, were morally justified and should not be prohibited by legislation.

There can be no doubt but that the findings of this Commission represent very accurately the views of every sane individual who has had an opportunity to adequately investigate the matter before attempting to form an opinion, and they will probably go a long way toward satisfying the minds of those who have been in doubt as to the utility or the advisability of vivisection.

## Transactions of the Forty-Eighth Session of the Homoeopathic Medical Society of State of Pennsylvania

**Bedford Springs, Pa. :: September 5, 6 and 7, 1911**

THE President, Dr. William A. Stewart, called the meeting to order at 9.30 A. M., September 5th, 1911.

The Divine blessing was invoked by the Rev. Mr. Eyler, Pastor of St. John's Reformed Church, Bedford, Pa.

Dr. E. H. Pond, President of the Allegheny County Medical Society, then delivered the following

### ADDRESS OF WELCOME :

*Mr. President, and Members of the Homœopathic Medical Society of the State of Pennsylvania:*

As President of the Homœopathic Medical Society of Allegheny County, at whose invitation you are meeting here, it becomes my duty and pleasure to extend to you, on behalf of our Society, a most hearty and cordial welcome. I wish also to assure you of the gratification felt by us in greeting so large a number of the well known and zealous representatives of our school from different parts of the State. We can not bid you "Welcome to Our City," but we believe, although our gathering amidst these surroundings is an innovation, that the result will be such a success, both from a scientific and social standpoint, that in arranging for future meetings, locations similar to this will be favorably considered. Here, away from the lures and temptations of the city, we have all of the conveniences and accommodations, and in addition, the historical and magnificent surroundings of this mountainous country. Breathing this clear atmosphere full of ozone should stimulate us to good work. If we find that on account of the accumulation of too much hot air, our room here should become oppressive, we can adjourn to the lawn under the trees, as has been done by other bodies meeting here, and hold our sessions in camp meeting style. When the question of extending an invitation to you was under discussion by our Society, the idea of inviting you to meet at some pleasant summer resort, was broached

and immediately favorably considered. After careful consideration of several localities, we finally decided that Bedford Springs was the most suitable, as regards ease of access and adequate accommodations, a decision which I do not think any of you will have reason to regret.

The deliberations and discussions of this session will be mainly upon scientific subjects, and according to the official program presented by the chairmen of the various bureaus, will no doubt be of more than ordinary interest, and give promise, not only of a highly interesting and busy, but even more than usually, an instructive and profitable session. It remains to our Society, through its entertainment committee to provide the social features of this session. How well they will have succeeded, you will be able to judge later. Although, perhaps the formal and scientific part of our meetings are of primary importance, we believe the social features bear a close second. The getting together in a social way, becoming acquainted one with another, the cultivation of good fellowship are, in my opinion, extremely important factors in binding us together as a school. One of the duties of our committee is to see that no one shall leave here without feeling acquainted with every other member. Upon the favorable auspices, under which we meet, I confidently base the hope and expectation that the present session will be one of great interest and enjoyment; one, indeed, upon which we may all look back, when we shall have returned to our respective fields of labor, with feelings and emotions of the most unalloyed pleasure, and all feel, that it was good to have been here.

Once again, ladies and gentlemen, in the name of the Homœopathic Medical Society of Allegheny County, I bid you welcome.

Dr. Gilbert A. Palen, of Philadelphia, then responded to Dr. Pond's address, as follows:

I feel sure that every member of this Society is intensely indebted to the Allegheny County Medical Society for this very warm welcome, and for the very excellent program which they have prepared for us. We certainly are in their debt now; and we will be very much more in their debt at the termination of this session, which bids fair to be the best session of the State Society which has ever been held.

I think the innovation which Dr. Pond has inaugurated is the keynote to our situation to-day. Formerly our meetings have been held in cities, or in meeting places where there were various distractions and the men were carried away from our meetings; furthermore, there was not the meeting of the mem-



bers with each other; so that we did not have the hearty comradeship which it is necessary to bring about in our State Society if we are to have a permanent and a strong organization.

In closing, I wish to thank the Allegheny County Society on behalf of the State Society, the president and the members thereof, for their very cordial welcome, and for their very excellent program which they have prepared for our benefit during this meeting. (Applause.)

Dr. Wm. A. Stewart, of Pittsburgh, then delivered the annual address of the President. (For full report of this address, see page 321.)

On motion, the address of the President was referred to a committee, consisting of Drs. Seip, Palen and Muller.

The Corresponding Secretary, Dr. E. M. Gramm, then reported that the correspondence of the Society had been carried on in the usual manner and a program for the annual meeting had been prepared. On motion, the report was accepted.

Dr. E. H. Pond, chairman, then presented the following:

#### REPORT ON ORGANIZATION AND STATISTICS.

*To the Homœopathic Medical Society of the State of Pennsylvania:*

Your Committee on Organization, Registration and Statistics herewith presents its annual report for publication. A list of the local societies, and of the hospitals and dispensaries of the State, under Homœopathic control is given, with detailed data as far as obtainable. We have been unable, after repeated requests to obtain any response to our queries for statistics, from a number of organizations; consequently, the report is not complete. We would again emphasize the importance of having a full report of every Homœopathic organization in the State; and would urge the members of the various institutions to see to it that they are properly represented in these annual reports. We desire to thank those who have answered our requests for information.

Respectfully submitted,

E. H. POND, M. D.,

*Chairman.*

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#### HOSPITALS.

J. Lewis Crozer Home for Incurables and Homœopathic Hospital, Upland, Delaware County. Incorporated 1897. Open for patients, 1903.

Executive Officer, Mrs. J. Lewis Crozer, Chester, Pa. Number of beds, 50; number of patients treated last year, 538. Supported by endowment.

Children's Homœopathic Hospital, Philadelphia. Incorporated 1877. Open to patients 1877. Executive Officer, Walter Strong, M. D., 2105 North Thirteenth street, Philadelphia. Number of beds, 155; number of patients treated last year, 1571; cured, 1290; died, 231. Estimated value of hospital and grounds, \$260,000. Sources of income, endowment, State aid and contributions.

Hahnemann Medical College and Hospital, Philadelphia. No report has been received from this hospital this year. Last year the Executive Officer was William J. Foulke, Franklin Building, Philadelphia.

Philadelphia Home for Infants, 4618 Westminster avenue, Philadelphia. Incorporated 1873. Open to patients 1873. Executive Officer, Dr. E. J. Whinna, 320 North Forty-first street, Philadelphia. Number of beds, 54; number of patients treated last year, 102; died, 2. Estimated value of hospital and grounds, \$25,000. Sources of income, donations, bequests, State appropriation and board of patients.

Keystone Sanatorium, 801 North Third street, Harrisburg. Open to patients 1910. Name and address of Executive Officer, G. W. Hartman, M. D., 1801 North Third street, Harrisburg. Sources of income, pay of patients.

Christian Home for Women, Locust street, Pittsburgh, N. S. Incorporated 1868. Open to patients 1868. Executive Officer, Mrs. J. F. Smith, 5718 Elgin avenue, Pittsburgh. Number of beds, 40; number of patients treated last year, 115; died, 2. Estimated value of hospital and grounds, \$30,000. Sources of income, State aid and subscriptions.

Hahnemann Hospital, 316 Colfax avenue, Scranton. Executive Officer, Eleanor S. Oakford, President. Number of beds, 75; number of patients treated last year, 941; cured, 786; relieved, 80; not relieved, 17; died, 58. Estimated value of hospital and grounds, \$150,000. Sources of income, donations, State appropriations, subscriptions and board of patients.

Homœopathic Medical and Surgical Hospital and Dispensary, Pittsburgh. Incorporated 1866. Open to patients 1866. Executive Officer, George L. McCloy, 5514 Baum street, Pittsburgh. Number of beds, 175; number of patients treated last year, 2380; cured, 1204; relieved, 989; not relieved, 68; died, 119. Estimated value of hospital and grounds, \$490,112.52. Sources of income, pay patients, State appropriation, income from endowment and contributions.

The Women's Southern Homœopathic Hospital, 724 Spruce street, Philadelphia. Incorporated 1896. Open to patients 1896. Executive Officer, Miss Annie Miller, 1911 Mt. Vernon street, Philadelphia. Num-

ber of beds, 35; number of patients treated last year, 416; cured, 323; relieved, 26; not relieved, 3; died, 11. Sources of income, voluntary contributions.

St. Luke's Homœopathic Hospital, 4414 North Broad street, Philadelphia. Incorporated 1896. Open to patients, 1896. Executive Officer, William H. Keim, M. D., 1716 North Eighteenth street, Philadelphia. Number of beds, 55; number of patients treated last year, 944; cured, 748; relieved, 90; not relieved, 23; died, 80. Estimated value of hospital and grounds, \$125,000. Sources of income, board of patients and State aid.

Homœopathic Medical and Surgical Hospital, 135 North Sixth street, Reading. Incorporated 1890. Open to patients 1891. Executive Officer, L. A. Schollenberger, M. D., Superintendent, 637 Walnut street, Reading. Number of beds, 75; number of patients treated last year, 853; died, 114. Estimated value of hospital and grounds, \$75,000. Sources of income, State aid, private patients and contributions.

The Walter Sanatorium, Walter's Park. Incorporated 1907. Open to patients, 1877. Executive Officer, Robert Walter, M. D., Walter's Park. Number of beds, 140; number of patients treated last year, 398; cured, 370; died, 5. Estimated value of hospital and grounds, \$200,000. Sources of income, pay of guests.

The Medical, Surgical and Maternity Hospital of the Women's Homœopathic Association of Pennsylvania, Twentieth and Susquehanna avenue, Philadelphia. No report has been received from this hospital this year. Last year the Secretary was Mrs. Frank B. Skinner, Provident Building, Philadelphia.

West Philadelphia General Hospital. No report has been received this year. Last year the Executive Officer was William H. Hillegas, M. D., 1001 Belmont avenue, Philadelphia.

Hospital of The Women's Homœopathic Association of Pennsylvania, Twentieth and Susquehanna avenue, Philadelphia. Incorporated 1884. Secretary, Mrs. F. B. Skinner, Provident Building, Philadelphia. Number of beds, 125; number of patients treated last year, 1218; cured, 1055; relieved, 116; not relieved, 11; died, 36. Estimated value of hospital and grounds, \$225,000. Sources of income, small endowment, State appropriation and board of patients, and small donations.

Florence Crittenden Home, 710 Harrison avenue, Scranton. Number of beds, 35; number of patients treated last year, 65; died, 1. Estimated value of hospital and grounds, \$40,000. Sources of income, State aid and public subscriptions.

#### DISPENSARIES.

Children's Homœopathic Dispensary, Philadelphia. Incorporated 1877. Opened to patients 1877. Secretary, Walter Strong, M. D., 2105 North



Thirteenth street, Philadelphia. Number of new patients treated last year, 7,444. Number of patients treated last year, 14,509. Prescriptions given last year, 28,906. Amount of funds belonging to dispensary, \$297.96. Number of visits made to patients outside, 233.

Hahnemann Hospital Dispensary, Broad street, above Race street, Philadelphia. Incorporated 1867. Secretary, William J. Foulke, Esq., Franklin Building, Philadelphia. Number of new patients treated last year, 12,883. Number of patients treated last year, 63,017. Number of prescriptions given last year, 20,861. Number of visits made to patients outside, 1,562.

Homœopathic Medical and Surgical Hospital and Dispensary, Pittsburgh. Incorporated 1866. Opened to patients 1866. Secretary, George L. McCloy, 5514 Baum street, Pittsburgh. Number of new patients treated last year, 3,495. Number of patients treated last year, 13,802. Number of prescriptions given last year, 6,167.

St. Luke's Homœopathic Dispensary, 4414 North Broad street, Philadelphia. Incorporated 1896. Open to patients 1896. Number of new patients treated last year, 2,226. Number of patients treated last year, 10,422. Number of prescriptions given last year, 8,157.

Women's Southern Homœopathic Dispensary, 724 Spruce street, Philadelphia. Incorporated 1896. Opened to patients 1896. Secretary, Miss Annie M. Miller, 1911 Mt. Vernon street, Philadelphia. Number of patients treated last year, 1,013. Number of prescriptions given last year, 2,576. Number of visits made to patients outside, 957.

Dispensary of the Homœopathic Medical and Surgical Hospital, Reading. Incorporated 1890. Opened to patients 1887. L. Schollenberger, M. D., Superintendent; W. W. Light, Secretary Board of Trustees. New patients treated last year, 4,393. Patients treated last year, 11,378. Prescriptions given last year, 11,378. Amount of funds belonging to dispensary, about \$500.

Dispensary of the Women's Homœopathic Association of Pennsylvania, Twentieth and Susquehanna avenue, Philadelphia. Incorporated 1884. Secretary, Mrs. F. B. Skinner, Provident Building, Philadelphia. New patients treated last year, 1,815. Patients treated last year, 12,647. Dispensary and hospital funds not separated.

#### SOCIETIES.

Homœopathic Medical Society of Allegheny County, Pittsburgh. Number of members, 109. Secretary, Edward P. Clark, M. D., 5801 Fifth avenue, Pittsburgh. President, E. H. Pond, M. D., Keenan Building, Pittsburgh. Annual dues, \$3.00. Time and place of meetings, third Wednesday of month, at downtown branch of the Pittsburgh Homœopathic Hospital.

Beaver County Homœopathic Medical Society, Beaver County. Organized 1883. Number of members, 9. Secretary, Dr. William Raymer, Beaver Falls. President, W. L. Coss, M. D., New Brighton. Annual dues, \$1.00. Time and place of meetings, monthly as fixed at meetings.

Clinico-Pathological Society of Philadelphia. Organized 1894. Number of members, 93. Secretary, Benjamin K. Fletcher, M. D., 1510 Christian street, Philadelphia. President, Samuel W. Sappington, M. D., 124 South Sixteenth street, Philadelphia. Annual dues, \$2.00. Time and place of meetings, third Saturday of each month, October to May, Hahnemann College.

Berks County Homœopathic Medical Society, Reading. Organized 1896. Number of members, 16. Secretary, Margaret Hassler-Schantz, M. D., 402 North Fifth street, Reading. President, W. F. Marks, M. D., 48 North Ninety-eighth street, Reading. Annual dues, \$1.00. Time and place of meetings, first Tuesday of each month at homes of the members.

Homœopathic Medical Society of Chester County. No report has been received this year. Last year, Secretary was L. Hoopes, M. D., West Chester, Pa.

The Homœopathic Medical Society of Chester, Delaware, and Montgomery Counties. Organized October 5, 1858. Number of members, 76. Secretary, Isaac Crowther, M. D., 800 Madison street, Chester. President, Charles R. Palmer, 302 North High street, West Chester. Annual dues, \$1.00. Time and place of meetings, second Tuesdays, bi-monthly, annual, October (West Chester), April (Hahnemann's Birthday) Chester. Other places in district.

Homœopathic Medical Society of Erie County. No report has been received this year. Last year, Secretary was C. A. McNeill, M. D., 134 East Eighteenth street, Erie.

Germantown Homœopathic Society of Philadelphia. No report has been received this year. Last year, Secretary was Landreth W. Thompson, M. D., 1701 Green street, Philadelphia.

Goodno Homœopathic Medical Society, Harrisburg, York, Columbia and Lancaster. Organized 1900. Number of members, 37. Secretary, John W. Reith, M. D. Lancaster. President, G. Willis Hartman, Harrisburg. Annual dues, \$1.00. Time and place of meetings, Harrisburg, York, Columbia and Lancaster, April, June, August and October. Annual meeting in Lancaster, October (second Thursday).

Lackawanna County Homœopathic Medical Society. No report has been received this year. Last year, Secretary was L. D. Roberts, M. D., 405 Wyoming avenue, Scranton.

Luzerne County Homœopathic Medical Society, Wilkes-Barre. Organized 1899. Number of members, 22. Secretary, O. K. Grier, M. D.,

389 North Main street, Wilkes-Barre. President, Dr. Robert Murdock, 194 South Main street, Wilkes-Barre. Time and place of meetings, every two weeks on a Friday night at the Wyoming Valley Homœopathic Hospital, Wilkes-Barre.

Homœopathic Medical Society of the County of Philadelphia. Organized 1866. Number of members, 300. Secretary, Percy A. Tindall, M. D., 1613 South Broad street, Philadelphia. President, Theodore J. Gramm, M. D., 1614 North Fifteenth street, Philadelphia. Annual dues \$2.00. Time and place of meetings, Hahnemann College, second Thursday of each month.

Homœopathic Medical Society of the Twenty-third Ward, Philadelphia. Organized October, 1881. Number of members, 30. Secretary, John Boileau, M. D., 804 Lehigh avenue, Philadelphia. President, William Erwin, M. D., 4844 Cedar avenue, Philadelphia. Annual dues, \$1.00. Time and place of meetings, third Wednesday each month at members' homes in rotation.

Philadelphia Academy of Medicine, Philadelphia. Number of members, 125. Secretary, Ralph Bernstein, M. D., 37 South Nineteenth street, Philadelphia. President, G. Harlan Wells, M. D., 1631 Arch street, Philadelphia. Annual dues, assessment. Time of meetings, first Thursday of each month.

Philadelphia Society for Clinical Research, Philadelphia. Organized 1905. Number of members, 17. Secretary, John F. Rowland, M. D., 430 North Fifty-second street, Philadelphia. President, Warren Mercer, M. D., 1705 Arch street. Annual dues, \$6.00. Time and place of meetings, third Wednesday of each month at offices of members.

Reading Homœopathic Hospital and Dispensary Association, Reading. Organized 1888. Number of members, 12. Secretary, Henry F. Schantz, M. D., 402 North Fifth street, Reading. President, F. E. Howell, M. D., 220 North Fifth street, Reading. Annual dues, \$1.00. Time and place of meetings, last Tuesday of month at Homœopathic Hospital, third Tuesday in January.

Schuylkill County Homœopathic Medical Society, Schuylkill County, Pa. Organized June 30, 1883. Number of members, 29. Secretary, George A. Merkel, M. D., Minersville. President, E. S. Straub, M. D., Minersville. Annual dues, \$1.00. Time and place of meetings, meet quarterly throughout county at selection of society.

Women's Homœopathic Medical Association of Pittsburgh. Organized October 11, 1899. Number of members, 9. Secretary, Mary E. Coffin, M. D., 3823 California avenue, Pittsburgh, N. S. President, Anna D. Varner, M. D., 616 Wood street, Wilkinsburg. Time and place of meetings, first Thursday of each month at the homes of the members.

North Penn Homœopathic Medical Society, Montgomery and Bucks



Counties (Lansdale Central). Organized January 30th, 1908. Number of members, 10. Secretary, H. O. Williams, M. D., Lansdale. President, S. C. Moyer, M. D., Lansdale. Place of meetings, at residences of members.

Homœopathic Medical Society of Lebanon County. No report has been received this year. Last year, Secretary was F. E. Bamberger, M. D., 20 North Seventh street, Lebanon, Pa.

Philadelphia Ophthalmological Society, Philadelphia. Not active. Hope to revive in the autumn. Last year, Secretary was W. M. Hillegas, M. D., 1001 Fourth street, Philadelphia.

Wilkes-Barre Homœopathic Medical Society. No report has been received this year. Last year, Secretary was O. K. Grier, M. D., 389 North Main street, Wilkes-Barre.

Homœopathic Medical Society of Blair County. No report has been received this year. Last year, Secretary was H. B. Replogle, M. D., Altoona, Pa.

The West Philadelphia General Homœopathic Hospital and Dispensary Society, Philadelphia. Organized 1904. Number of members, 25. Secretary, William McKenzie, M. D., 313 North Sixty-third street, Philadelphia. President, Dr. H. M. Gay, 1685 North Fifty-fourth street, Philadelphia. Time and place of meetings, at West Philadelphia Homœopathic Hospital and Dispensary, third Friday of each month.

Organon Medical Club. Chester. Organized 1887. Number of members, 14. Secretary, D. P. Maddux, M. D., northeast corner Madison and Eighth street, Chester. President, R. P. Mercer, M. D., 223 West Third street, Chester. Annual dues, as assessed. Time and place of meetings, monthly at offices of members.

Raue Medical Club. No report has been received this year. Last year, Secretary was H. D. Kessler, M. D., 1202 Sixteenth street, Altoona.

Carl V. Vischer Medical and Surgical Society, Philadelphia. Organized January 17, 1907. Number of members, 46. Secretary, W. H. A. Fitz, M. D., 1435 Girard avenue, Philadelphia. President, James H. Closson, M. D., 53 West Chelten avenue, Germantown. Annual dues, \$10.00. Time and place of meetings, first Tuesday of October, December, February and April, at 1429 Poplar street, Philadelphia. Annual meeting at Art Club.

The Euphron Club, Philadelphia. Organized October 13, 1906. Number of members, 25. Secretary, G. Morris Golden, M. D., 1449 Venango street, Philadelphia. Chairman elected at each meeting to preside at the next meeting. Annual dues, \$20.00. Time and place of meetings,

second Saturday of January, April and October, at such places as may be chosen.

Hahnemann Club of Philadelphia. Organized 1872. Number of members, 8. Secretary, Thomas S. Dunning, M. D., 1328 North Fifteenth street. President, John J. Tuller, M. D. Annual dues, assessments. Time and place of meetings, Philadelphia as appointed.

Oxford Medical Club of Philadelphia. Organized 1885. Number of members, 17, number limited to 18. Secretary, Lewis B. Griffith, M. D., 2449 Columbia avenue, Philadelphia. President, A. Layman, M. D., 1630 North Eighteenth street, Philadelphia. Annual dues, \$5.00. Time and place of meetings, first Friday of each month. The essayist entertains the club wherever he selects.

Philadelphia Medical Club. No meeting for more than a year. No changes in officers or members. Last year, Secretary was Edwin H. Van Deusen, M. D., 2101 Tioga street, Philadelphia.

W. B. Van Lennep Clinical Club. No report has been received this year. Last year, Secretary was Arthur Hartley, M. D., 2101 West Susquehanna avenue, Philadelphia.

The Women's Homœopathic Medical Club of Philadelphia. Organized 1883. Number of members, 14. Secretary, Margaret Burgess Webster, 1703 Chestnut street, Philadelphia. President, Mary Branson, M. D., 1504 Locust street, Philadelphia. Annual dues, \$1.00. Time of meetings, first Tuesday evening of November, February and May.

East End Doctors' Club of Pittsburgh, East End. Number of members, 20. Secretary, C. I. Wendt, M. D., 600 Shady avenue, Pittsburgh. President, J. H. McClelland, M. D., Fifth and Wilkins avenue, Pittsburgh. Annual dues, \$1.00. Time and place of meetings, monthly at members' homes.

Alumni Association of Hahnemann Medical College of Philadelphia. Organized 1848. Number of members, 1757. Secretary, Edwin L. Nesbit, M. D., Bryn Mawr. President, William H. Keim, 1716 North Eighteenth street, Philadelphia. Time and place of meetings, Alumni Hall, Hahnemann College, during commencement week.

Homœopathic Pharmaceutical Association. No report has been received this year. Last year, Secretary was E. P. Anshutz, M. D., P. O. Box 931, Philadelphia.

D. P. Maddux Club. No report has been received this year. Last year, Secretary was R. C. Casselberry, 700 Madison street, Chester.

Hahnemann Round Table of Philadelphia. Organized 1906. Number of members, 10 active. Secretary, Margaret C. Lewis, M. D., 4027 Spring Garden street, Philadelphia. President, William R. Powell, M. D., 6824

Quincy street, Philadelphia. Annual dues, \$1.00. Time and place of meetings, 1703 Chestnut street, last Friday of each month.

Delaware County Homœopathic Medical Society, Delaware County, Pa. Organized 1898. Number of members, 27. Secretary, George C. Webster, 311 West Seventh street, Chester, Delaware County, Pa. President, J. P. Van Keuren, Chester, Pa. Annual dues, \$1.00. Time and place of meetings, bi-monthly. Various places in county.

West Branch Homœopathic Medical Society, Lycoming County, Pa. Organized 1908. Number of members, 16. Secretary, Dr. E. C. Blackburn, 322 Elmira street, Williamsport, Pa. President, Dr. James A. Osborne, Milton, Pa. Annual dues, \$1.00. Time and place of meetings, bi-monthly at offices of members.

Lehigh Valley Homœopathic Medical Society, Lehigh Valley. Organized 1890. Number of members, 35. Secretary, S. Clarence Swartz, M. D., 124 South Sixth street, Allentown, Pa. President, William A. Seibert, M. D., 43 North Fourth street, Easton, Pa. Annual dues, \$1.00. Time and place of meetings, first Thursday of the month. Every third month, March, June, September and December. At Allentown, Bethlehem and Easton successively.

Dr. H. S. Weaver then presented the following:

#### REPORT OF THE BOARD OF TRUSTEES.

The Board of Trustees wish to report that at a special meeting, held at 1433 Spruce street, Philadelphia, on October 18th, 1910, the recommendation made by the State Society to accept the HAHNEMANNIAN MONTHLY's offer, after due deliberation and carefully going over the various articles of agreement between the State Society and the HAHNEMANNIAN MONTHLY, with a few alterations, was finally accepted. The members present were Drs. Gilbert, Bernstein, Maddux, Schantz and Weaver.

Dr. Maddux was elected State Society Editor.

A resolution was also passed requesting the Corresponding Secretary to turn over all papers and notes to the HAHNEMANNIAN MONTHLY and to obtain a receipt for same.

Another special meeting of the Board of Trustees was held on April 8th, 1911. Members present were: Drs. Stewart, Palen, Bernstein, Maddux and Weaver. A motion was made to accept the invitation of the Allegheny County Medical Society to meet at Bedford Springs in September.

The regular meeting of the Board of Trustees of the Pennsylvania State Homœopathic Medical Society was held at Bedford Springs, September 4th, 1911. The members present



were: Drs. Maddux, Bernstein, Palen, Schwartz, Heilner, Weaver and President Stewart.

A motion was made, seconded and carried that a committee be appointed to go over the By-Laws of the Society and present such alterations as are found necessary to conform to our new plan of publication. Drs. Maddux and Bernstein were appointed.

The books of the Treasurer were audited and found correct.

The following bills were ordered paid:

Dr. Ella D. Goff, traveling expenses .....	\$50.00
Dr. E. H. Pond, traveling expenses .....	50.00
G. H. McCandless, printing .....	33.45
Smith & Edwards, printing .....	50.50
Howe Addressing Company .....	17.96
Membership Committee .....	75.00
Total .....	<u>\$276.91</u>

The question of new members being admitted for a flat sum of three dollars was then taken up and thoroughly discussed, and the following resolution was thought best to be presented to the Society in the Trustees' report:

In view of the fact that the suggestions and recommendations made by the Board of Trustees of this Society, to-wit:

That for one year physicians properly approved may be elected to membership upon the payment of three dollars. Therefore, be it resolved, that Article III, Section II be suspended and the names presented during the present year, who have been properly approved by the Board of Censors, be presented to the Society for election to membership.

H. S. WEAVER, *Secretary*.

Before the adoption of the report of the Board of Trustees a discussion took place in regard to the power of the Board to authorize the admission of new members at this meeting of the Society upon the payment of three dollars and remit the initiation fee of two dollars.

It was the consensus of opinion at the meeting that the Society only could authorize a remission of the initiation fee, and the motion to adopt the report of the Board of Trustees was amended in such a way that the report was adopted with the exception of the section relating to the admission of new members.

Before the motion was put by the President, at the request of Dr. E. M. Gramm, the contract of the State Society with the *HAHNEMANNIAN MONTHLY* was read to the Society.

Dr. J. J. Tuller next presented the following:

REPORT OF THE LEGISLATIVE COMMITTEE OF THE HOMŒOPATHIC MEDICAL SOCIETY OF THE STATE OF PENNSYLVANIA.

*Mr. President and Members of the Homœopathic Medical Society of the State of Pennsylvania:*

Your Committee on Legislation desires to make the following report:

It is unnecessary in a general report of this character to go into the detailed account of the meetings held. It was believed by the members of your committee, until about the first of December, 1910, that there would be no Medical Legislation during the session of the Legislature of 1911. At this time, however, notice was served upon your chairman by the Committee on Medical Legislation and Public Policy of the Medical Society of the State of Pennsylvania, that a bill would be introduced at the beginning of the session of the Legislature. Your chairman obtained a copy of this bill, and called your committee together to take action upon it. Following the instruction of this Society at its session in 1909, your committee unanimously voted to oppose this bill, it being a counterpart of the bill that was presented and was defeated at the legislative session of 1909. The committee, therefore, ordered the revision of the proposed bill indorsed by this Society at its session in 1909, and the preparation of that bill for introduction as an opposing element to the bill to be introduced by the Legislative Committee of the Medical Society of the State of Pennsylvania, and it will be unnecessary to go into the detailed description of the manœuvering that occurred between the two committees, which finally resulted in the bringing forth of the bill that was later to be enacted into the present law. It, however, required close attention on the part of your committee to protect the interests of the Homœopathic profession of this State. As a result, your chairman believes that not only have the interests of the Homœopathic profession been protected, but this State has enacted into law a system, for Medical Education and Licensure, far in advance of the Medical Law of any other State in the country, and one that certainly should deal justly with all schools of medicine and all conditions that could possibly arise resting upon the basis of Medical Education.

The salient points in this bill can be summed up as follows: It takes the question of Medical Licensure out from under the police surveillance, and places it under the control of the Department of Public Instruction of this State, by creating a Bureau which shall be a department of the Department of Public Instruction, that shall consist of seven members, divided as follows: The Superintendent of Public Instruction, and the State Commissioner of Health; three members to be selected by the Governor from the at present three legally incorporated medical societies of the State, namely: The Medical Society of the State of Pennsylvania, the Homœopathic Medical Society of the State of Pennsylvania, and the Eclectic Medical Society of the State of Pennsylvania, and two to be appointed by the Governor, provided that these two do not represent the same school or system of medicine. Your committee succeeded in further safeguarding the interests of the Homœopathic profession, by forcing a clause that all vital points to be considered by this Bureau, namely: Questions bearing upon the refusal, revocation or suspension of a license to practice medicine or dealing with the educational system, such as the suspension of the activity of a college, should be decided only by the unanimous vote of all seven members of this Bureau. The Bureau shall be known as the Bureau of Medical Education and Licensure of the Department of Public Instruction. The bill provides for the character of the course, the branches to be studied, and particularly as to weeks and hours per week in each of the four years to be employed as a legal medical course in this State. It thereby sets the standard of Medical Education. It also provides for the standard of preliminary education. It requires that through this Bureau annual inspection shall be made of every Medical Educational Institution in the State, and such inspection shall be reported in full to the Bureau, and such institutions as do not attain to the necessary requirements as provided for by this act, shall, after due notification, if not corrected, be suspended by rendering its students ineligible to license, until such time as its curriculum, equipment and facilities for teaching shall be brought up to the standard required by this act. This suspension, however, requires the unanimous consent of all seven members of the Bureau. The bill again provides for the examination of students during the last thirty days of their senior course in the institution in which they are pursuing their studies; said examination to include those students who have been recommended by the Faculty of the College, and at the discretion of that body this examination shall be final, the student receiving his license upon payment of a



fee of twenty-five dollars, and his receiving his graduating diploma from the college in which he pursued his work. Those not recommended by the Faculty to take this examination, or who have taken it and failed, and yet have passed the Faculty final examinations, may be permitted to come before this Bureau at its regular examination to be held after the close of the college term. It also provides that at the close of the second year, a student may be examined in Anatomy, Physiology, Chemistry as applied to medicine, Hygiene, and Preventive Medicine, and should failure occur, said student is again eligible for the examination in these branches at the close of his senior year. Special stress should be laid upon the fact that all of this work belongs to and is a part of the Department of Public Instruction, and directly under the supervision of the Superintendent of Public Instruction.

Another striking and important feature of this bill is the granting of the power, the prescribing as a duty of this Bureau, the examination of any person pretending to a knowledge of any minor branch or branches of medicine and surgery. For the purpose of establishing regulation of State Licensure, it provides that the Bureau shall have such oversight over the instruction in schools or colleges pretending to teach such minor branch or branches of medicine and surgery as is provided for in the case of medical schools and colleges. It also permits that this Bureau shall conduct such limited examinations as are in their judgment necessary for the purpose of determining whether or not the applicant has the proper degree of knowledge to practice these branches, and it provides for the licensure of such applicants to the practice of these minor branches of medicine and surgery. This act also provides for the refusal to grant, the revocation or suspension of a license to practice medicine and surgery, for the following reasons: "The conviction of a crime involving moral turpitude; habitual intemperance and the use of ardent spirits or stimulants; narcotics or any other substance that impairs the intellect and judgment to such an extent as to incapacitate for the performance of professional duties," as well as a penalty for the violation of the law.

This is but a simple summary, but I believe it brings out the important facts which will readily be recognized as the basic points of the bill indorsed by this body at its session in 1909.

One other act of the Legislature of this year I am sure will be of interest to this Society. A bill that was introduced in the Senate by Senator Tustin to provide for the standardization of the high school courses throughout the State. This bill was

known as the Professional Education Bill, and it provides for the creation of a Bureau of Professional Education as a department of the Department of Public Instruction. Such Bureau to have the power to determine, evaluate, standardize and regulate the preliminary education of those to be hereafter admitted to the practice of Medicine, Dentistry or Pharmacy in this State. It then, will give the Department of Public Instruction the right to regulate the standard of the High Schools of the State of Pennsylvania, a privilege never before granted to the Department of Public Instruction, and certainly a long felt need in this State.

As chairman of your committee, I have no hesitation in saying, your Committee on Medical Legislation was the potent factor in the enacting of these two bills, which were approved by the Governor, therefore became laws. No man in the face of these facts can at any time in the future say that the Homœopathic profession in the State of Pennsylvania is not in the line of higher education, because it has not followed, but led the way to the highest standard of Medical Education that exists in any State in this country, and I feel to-day that we may be proud of the position we have taken.

Most respectfully submitted.

This report was accepted with the thanks of the Society.

Dr. E. M. Gramm then presented the report of the Publication Committee and stated that no work had been done by the committee during the past year because of the publication of the transactions in the *HAHNEMANNIAN MONTHLY*.

He suggested that a By-Law be adopted to authorize the publication of the transactions in the official journal of the Society.

Dr. Ralph Bernstein then presented the following :

#### REPORT OF THE MEMBERSHIP COMMITTEE.

The committee takes pleasure in presenting to you one hundred and twenty-five names for membership in the Society. Thirty of these are from the graduating class of the Hahnemann Medical College of Philadelphia.

This is the first time that we have been able to get almost all of the graduating class. This is due to the fact that graduates are admitted into the membership of the Society and receive the *HAHNEMANNIAN MONTHLY* for half the amount that these would formerly have cost.

After considerable discussion as to the cost of getting new members into the State Society, the report of the Membership Committee was adopted.

Dr. C. P. Seip then presented the

#### REPORT OF THE COMMITTEE ON THE HERING MONUMENT.

Owing to the death of a number of the members of this committee very little has been accomplished. The Philadelphia members seem to have shown little interest in the work.

Unless there is something more done I would move that the committee be discharged.

After some discussion the motion of Dr. Seip was put before the Society and lost.

Dr. Pond then read the list of applicants for membership in the Society,

It was moved and seconded that the initiation fee of two dollars be remitted. The motion was voted upon by the Society and carried.

Dr. Emma T. Schreiner then presented the report of the

#### COMMITTEE FOR COMBATING SOCIAL EVIL.

Your Committee for Combating Social Evil reports a very widespread interest among all classes of people. Dr. Elliott, ex-president of Harvard University, has been collecting expressions of opinion from members of the medical profession as to whether social diseases should be publicly reported. The majority of physicians consulted by him are opposed to the obligatory report, saying no one would consult a reputable physician; all would go to quacks and charletans who evade the law and who might retard a cure by improper treatment. Your committee urges that at a given time, say five years hence, all *new cases* of venereal disease shall be publicly reported. In the meantime, educate the children. Lectures to young men, though helpful are ten years late. The adults most needing instruction are parents and teachers. Primers of complete Anatomy and Physiology are under compilation.

E. T. SCHREINER,  
*Chairman of Committee.*



Dr. William F. Baker then presented the

REPORT OF THE NEUROLOGIST.

DR. PITCAIRN, OF ALTOONA, PA.

Thursday, July 20, 1911.

Dr. Hugh Pitcairn, president of the Altoona Tribune Company, former United States Consul General at Hamburg, Germany, well known throughout the State and resident of Harrisburg, died late yesterday afternoon at Hamburg, whither he had gone in the hope of being benefited in health.

Dr. Pitcairn, for the last year or more, had not been enjoying his usual good health, and during the early spring decided to make a European trip in the hope that his health might be benefited by the sea voyage, the change of climate and the scenes about Hamburg and the bathing at Carlsbad. Accompanied by his wife and daughter, Miss Fannie, he left their home in Harrisburg on May 24th for the trip abroad. He visited London en route to Hamburg and was in attendance at the coronation of King George, of England. After viewing the ceremonies he, his wife and daughter proceeded on to Hamburg, leaving London about July 5th. His last serious illness dated from his arrival in London, where specialists were consulted regarding his ailment, which was diagnosed as cancer of the stomach. His condition was regarded as such that an operation was considered too serious for him to undergo. After arriving at Hamburg his decline continued until the final summons came and ended a long, useful career, as well as a varied one, as he had been engaged in railroading, medicine, publishing and diplomacy.

Dr. Pitcairn was an active member of the State Society.

DR. FRANK FOSTER CRANDELL, OF TURTLE CREEK, PA.

Dr. Crandell died April 10th, 1909, from plastic pleurisy, aged 40 years.

He married S. Gertrude Coffin, of Pittsburg, September 11th, 1899, and entered the Cleveland Homœopathic Medical College the same year. His loss is deeply felt by the wife and four little folk, and also by the whole community where he practiced, for he was loved and respected as a faithful physician and earnest Christian.

Dr. Crandell was an active member of the State Society.

GEO. W. SMITH, M. D.

Dr. Geo. W. Smith was born in Haverford, Pa., April 20th, 1843. Being a son of Judge Bartine Smith, he was educated in the public schools. He graduated from Hahnemann College in 1876.

He was visiting physician to the Children's Homœopathic Hospital, president of the Carl V. Vischer Medical and Surgical Association, a member of State and County Societies, of the Germantown and Oxford Medical Clubs, and of the Historical Society of Pennsylvania; also a member of Crescent Lodge 493 F. & A. M., Keystone Chapter and St. John's Commandery.

Dr. Smith married in 1870 and has three children, two sons and one daughter.

Interment at Chester, Pa.

The next order of business was the consideration of the amendment of Article III, Section II of the By-Laws in order to provide that an active member who has retired from the practice of medicine, in consideration of his services to the cause of Homœopathy, may be continued as an active member without the payment of dues.

By vote of the Society this motion was carried.

It was then moved by Dr. E. M. Gramm that Dr. C. M. Thomas, of Philadelphia, be placed upon the list of members of the Society without the payment of dues, he, having retired from the practice of medicine.

The motion was duly seconded and carried.

WEDNESDAY, SEPTEMBER 6TH.

The meeting was called to order by the President, Dr. William A. Stewart.

The Board of Censors recommended the election of Dr. H. R. Arndt to honorary membership. They also recommended the election of the following physicians to active membership in the Society:

Drs. H. E. Aldrich, J. M. Armaiz, H. B. Adams, W. H. Abbott, Jos. A. Brooke, E. M. Bond, E. Bieber, W. L. Bond, M. S. Bringman, F. E. Bristol, F. L. Baum, C. W. Bradford, I. L. Baum, F. C. Battiger, T. L. Blaer, W. A. Bennett, C. F.

Books, C. Y. Boyd, J. F. Crouthamel, E. B. Craig, F. R. Clark, E. V. Dunnington, M. H. Dinsmore, F. L. Dewees, S. L. Driebelbis, H. F. Ewing, F. C. Emrey, F. B. Edmundson, F. R. Fleming, B. B. Fenimore, Samuel Friedmann, B. K. Fetcher, J. Flinn, H. L. Fry, J. H. Friedmann, L. L. Friedmann, D. W. Ensminger, J. M. Godfrey, O. B. Wait, Edd. K. Golding, J. Q. Griffith, P. H. Gerhardt, B. W. Genung, W. D. Garvin, O. K. Grier, W. L. Hicks, W. H. Hoffman, R. C. Hoffman, J. Hancock, J. M. Hutchings, G. A. Hopp, G. W. Heck, W. H. Hatfield, C. H. Harvey, H. H. Hill, M. Hughes, O. J. Jordan, N. H. Jenkins, J. A. Johnson, R. M. Johnson, C. B. Jennings, Wm. Earl Kistler, C. S. Kinney, A. J. Kaiser, S. H. Kirkpatrick, C. J. Lewis, C. L. Ley, R. W. Larer, H. W. Lambert, W. E. Lang, F. W. Lang, J. C. Lingle, C. P. Lingle, C. A. Ley, Mifflin Mercer, E. J. Meley, S. A. Mullin, W. H. McKenzie, C. M. McCoy, W. H. McKenna, F. O. Nagle, Chas. C. Ogle, W. R. Pierce, F. C. Peters, W. C. Powell, Jr., H. R. Plummer, S. W. Reeves, D. M. Roudabush, Wm. Raymer, C. G. Robinson, J. K. Redman, P. W. Riddles, W. B. Rile, F. S. Shuman, C. F. Souder, Geo. P. Stubbs, F. R. Shute, J. A. Stackhouse, A. G. Stetson, J. C. Stewart, J. H. Smith, S. C. Swartz, L. A. Schollenberger, J. M. Spang, J. J. Sweeney, R. E. Sheen, E. A. Steinhilber, G. A. Sayres, W. J. Snyder, H. L. Stern, H. Scatchard, W. Sankey, C. A. Vroom, Jr., Frank A. Whiteman, H. K. White, E. G. Whinna, J. M. E. Ward, G. B. Weaver, M. D. Youngman, W. M. Yost, Mary J. Cochran, C. Kaler, F. G. Koehler, F. A. Irwin.

# TREASURER'S REPORT.

(For the Year Ending September 2, 1911.)

Ella D. Goff, Treasurer, in account with Homœopathic Medical Society of Pennsylvania:

DR.

To balance from last year .....	\$655 37	
To annual dues collected .....	1,363 00	
		<hr/> \$2,018 37

CR.

1910—

September 20, by Order No. 111, to George B. Cock, Stenographer .....	\$100 00
September 20, by Order No. 112, to Ella D. Goff, printing, postage and traveling expenses .....	65 12



September 20, by Order No. 113, to E. H. Pond, stationery and traveling expenses .....	69 60	
September 20, by Order No. 114, to E. M. Gramm, printing, postage, stenographer, traveling ex- penses, Polk Directory .....	182 93	
September 20, by Order No. 115, to H. F. Schantz, printing, postage .....	37 97	
September 20, by Order No. 116, to Reading Eagle, printing .....	32 75	
September 20, by Order No. 117, to Ralph Bernstein, for T. F. Arnold, Stenographer to Press Com- mittee .....	5 00	
1911—		
August 8, by Order of President W. A. Stewart, to Ralph Bernstein for Membership Committee....	75 00	
September 2, by balance .....	1,450 00	
		\$2,018 37

Respectfully submitted,

ELLA D. GOFF,

Treasurer

Pittsburgh, Pa., September 2, 1911.

## THURSDAY, SEPTEMBER 7TH.

The meeting was called to order by the President, and the minutes of the previous day were read and approved.

Dr. E. M. Gramm requested that his name be withdrawn as a candidate for the office of Corresponding Secretary.

As there remained but one candidate for each office it was moved and seconded that the Secretary be instructed to cast a ballot for the officers nominated.

The motion was carried.

The Secretary then announced the election of officers for the ensuing year:

President, Dr. Gilbert J. Palen, of Philadelphia.

First Vice-President, Dr. H. S. Nicholson, Pittsburgh.

Second Vice-President, Dr. R. L. Piper, Tyrone.

Recording Secretary, Dr. E. H. Pond, Pittsburgh.

Corresponding Secretary, Dr. H. S. Weaver, Philadelphia.

Treasurer, Dr. Ella D. Goff, Pittsburgh.

Necrologist, Dr. William F. Baker, Philadelphia.

Censor, Dr. Theodore J. Gramm, Philadelphia.

Trustees: Dr. William A. Seibert, Easton; Dr. A. P. Bowie, Uniontown; Dr. H. M. Bunting, Norristown.

Dr. Gilbert J. Palen then moved that the matter of selecting a place for holding the next meeting be referred to the Board of Trustees.

This motion was seconded and carried.

Dr. Palen moved that a committee of three be appointed from the members of the Society to investigate the financial obligations existing between the HAHNEMANNIAN MONTHLY and the Society. Said committee to present a written report to the Board of Trustees at as early a date as possible.

This motion was seconded and carried.

Dr. Palen next read the following motion:

"I move that the paragraph in Article IX referring to the publication committee be suspended and that the President be authorized to appoint a committee of three having the power to prepare a report of the transactions of these meetings and subject to the contracts and agreements previously made upon this subject."

This motion was seconded by Dr. E. M. Gramm and was carried.

At the closing session of the Society, Dr. H. R. Arndt was unanimously elected as an honorary member.

Votes of thanks were extended to the management of the Bedford Springs Hotel and to Dr. William A. Stewart, the retiring President of the Bedford County Homœopathic Medical Society, and also to the Allegheny County Medical Society.

The meeting was adjourned sine die at 6 P. M., September 7th, 1911.

## GLEANINGS

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**PINEAPPLE JUICE IN ANOREXIA.**—The author administered fresh pineapple juice to 150 cases in which anorexia was a symptom, including patients with simple anemia, convalescents from malaria, nephritis, pneumonia, typhoid fever, acute and chronic gastritis, and pulmonary tuberculosis. In chronic diseases of the stomach in general, especially in alcoholic cases, the juice was productive of considerable benefit. In gastric and duodenal ulcer, however, it was not well borne. In nephritis the juice proved useful after the acute attack had passed off, and in tuberculous cases with anorexia it was also of assistance. In anorexia following attacks of acute hepatitis, hepatic colic, and acute cholecystitis, as well as in chronic liver and gall-bladder cases, the juice materially improved the appetite. In the chronic cases the feces, previously scanty, containing much macroscopic undigested food and having a light color, were considerably altered and improved; upon omitting the juice temporarily they returned to their former condition. In a number of neurotic patients seemingly unable to eat, improvement after administration of the juice was quite apparent, though mention had not been made as to the probable effect expected from the remedy.—*S. Floersheim (Dietetic and Hygienic Gazette, February, 1912).*

**END RESULTS OF GALLSTONE OPERATION.**—Dr. L. Arnsperger (*Munch. med. Wochensch.*, No. 1, 1912) analyzes the statistics of the surgical clinic of Heidelberg, comprising 230 cases with a primary operative mortality of 16, that is, 6.9 per cent. From his investigations as to the most useful method of gallstone operation and the prognosis, the author draws the following conclusions: 1. Of 147 cases of operation the later history of which was ascertained by correspondence, chiefly with the family physician, or by personal examination, 113 cases (64.6 per cent.) were completely cured, while 19.7 per cent, still exhibited slight disturbances, but not sufficient to keep them from work, thus giving a total of 84.3 per cent. of satisfactory results. Of the remainder, 2.1 per cent. of the patients suffered with disorders having no relation to the operation, while 13.6 per cent. were either unimproved or had to submit to a recurrence operation. 2. The best results were obtained especially in inflammatory conditions of the gall bladder, those from cholecystectomy being particularly satisfactory. Conditions are much less favorable in patients with numerous small stones and a patent cystic duct who have previously passed calculi. In these extirpation of the gall bladder is advisable even when there are no marked changes in its walls. Cholecystostomy does not afford any positive guarantee of the removal of all the small calculi, while concretions in the deep ducts are frequently overlooked even when these are opened up and probed. 3. After removal of long exist-



ing stones in the choledochus concretions formed in the liver may gradually slip downward and give rise to false recurrences. 4. After cholecystostomy any disturbances that may recur are due in one-half the cases to stones that have been left behind, while in the other half they result from an inflamed shrunken, strongly adherent gall bladder. True recurrences were never observed in the clinic. 5. Cholecystostomy is therefore to be rejected in all inflammatory processes of the gall bladder with a tendency to adhesions and secondary contraction. It is also necessary to prevent fixation of the top of the gall bladder, especially when greatly distended, to the abdominal wall. 6. Hence cholecystostomy is only to be undertaken where there are a few large calculi that can be radically removed, where the gall bladder wall is intact, or when special conditions, weakness of the patient, difficult anesthesia, tense adhesions, and deep position of the gall bladder contraindicate extirpation. 7. Complications of gallstone disease, which later may give rise to disorders of the pancreas, and movable kidney on the right side deserve particular consideration.—*International Jour. of Surgery*.

**SPLANCHNOPTOSIS, MECHANICAL TREATMENT OF.**—A simple and effective method of securing adequate support for the viscera in Glenard's disease is described by the author. A strip of zinc oxide adhesive plaster 2 or  $2\frac{1}{2}$  inches wide and about 5 or 6 inches long is placed transversely across the extreme lower abdomen, the hair having previously been shaved clean. To each end of the adhesive is attached a bandage of about the same width, long enough to reach around the body above the iliac crest and be fastened behind. Loosening of the ends of the adhesive through the traction exerted by the bandage can be prevented by a narrow vertical strip of adhesive placed over each end. The bandage is well padded with cotton, either folded within it or applied to the body immediately beneath. This arrangement permits of easy adjustment to the required degree of tightness, and, in particular, avoids the skin irritation caused by adhesive carried firmly around the body. By means of the fixed point of support in the lowest zone of the anterior abdomen, the pressure is applied exactly where it does the most good. Some irritation beneath the plaster is produced at first; but by occasionally removing it, cleansing the skin, and using a dusting powder for twenty-four to forty-eight hours, the irritation will be overcome, and the strap can finally be used continuously.

The fact is emphasized by the author that mechanical support is only an auxiliary in the treatment of splachnoptosis. Fundamental defects in the musculature, lack of tone in visceral supports, imperfect circulation and innervation, together with the neurasthenic state so often associated, must all be therapeutically met. Massage, electricity, appropriate treatment of the gastrointestinal tract, prolonged mechanical support, with correct living and suitable diet, constitute the most effective measures.—*G. W. McCaskey (Journal of the American Medical Association, October 28, 1911)*.

**PREGNANCY AND LABOR, MANAGEMENT OF APPENDICITIS IN.**—During the first three months of pregnancy the treatment of appendicitis should be

the same as in the non-pregnant state; but if immediate operation is not performed and the patient is carried through an attack without removal of the appendix this should be done soon afterward, since the danger of recurrence later in pregnancy at a more unfavorable period is great. After the third month the treatment should be immediate removal of the appendix as soon as the diagnosis is made, since the high mortality of this complication is due to delay. This applies especially to the later months, when, due to the greater congestion and increased intra-abdominal pressure, the inflammatory changes are apt to be very marked, with easy perforation. The indication for operation applies to the mild cases as well as the severe ones, and no plan of delaying to determine the severity of the attack is justifiable.

If an attack of appendicitis comes on during labor the uterus should be emptied without much delay and then the appendix removed. If the attack comes on before labor, even if at full term, the uterus should not be emptied until after the appendix has been removed or the abscess drained if pus has developed. If general peritonitis is already present the uterus should first be emptied by the vaginal route by a rapid method, and the abdominal operation then performed.

The same necessity for prompt interference holds good when symptoms of appendicitis appear during the puerperium. In a large percentage of cases the exacerbation is due to the breaking of adhesions or rupture of a pus sac by the sudden decrease in size of the uterus.—*A. H. Bill (Cleveland Medical Journal.)*

OINTMENTS, WITH SPECIAL REFERENCE TO THE SUBSTANCES USED AS BASES.—Wild (*British Medical Journal*) has made a number of experiments to determine the relative protective and penetrative powers of the various bases, and also the extent to which certain active drugs were absorbed by the skin when applied to it in the various combinations. The experiments were made by rubbing a carefully weighed quantity of the ointment or base into a definite area of skin for a fixed time. The ointment was then scraped off the rubbing finger and the surface of the skin by a dulled Gillette safety razor blade fixed in a convenient handle, and again weighed. To avoid the necessity of wiping the instrument, the scraper is weighed with the ointment both before and after rubbing. With a little practice, consistent results may be obtained. The loss of weight represents the amount of ointment absorbed, together with the amount lost in manipulation; as the latter is fairly constant in dealing with preparations of a similar consistency, the results afforded a relative indication of the respective amounts absorbed. There may, of course, be a possible slight gain from secretion and epidermis removed from the skin by scraping, but, if the skin be dried before the rubbing, experiment has shown that this factor may be neglected, as it is the same for each application and does not affect the relative results.

These experiments are still in progress, but sufficient results have been obtained to confirm the generally accepted views as to the relative penetrative powers of the usual bases.

Soft paraffin and paraffin ointment appear to be hardly absorbed at all, but remain on the skin as a protective layer for a considerable period.

Lard and olive oil are absorbed to a considerable extent, about 15 per cent., after two minutes' rubbing. Hydrous wool-fat, 20 per cent., provided the proper amount of water is present; old samples partially dried are less absorbed. Owing to its powerful adhesive properties, no reliable result was obtained from anhydrous wool-fat.

The greatest loss of weight occurred from a mixture of equal parts of glycerin of starch and hydrous wool-fat, which is a useful base when a comparatively non-greasy emollient is required.

RELATIONSHIP OF SYPHILIS AND TUBERCULOSIS.—Gouget (*Jour. des Praticiens*) says that while tuberculosis does not predispose to syphilis, the latter certainly does to tuberculosis. Although it has been noted that laryngeal or tracheobronchial syphilis has actually resulted in the implantation of the tubercle bacillus, this is not so usual. It is rather the debilitating effects of syphilis which predispose to tuberculosis. Patients in the secondary stage are much more susceptible than old and tertiary syphilitics, unless, indeed, in the latter case there are suppurative lesions, tabes, or general paralysis. Sergeant, after careful investigation of the matter, is stated to have come to the conclusion that tuberculosis is intimately bound up with syphilis, although the latter may be only a remote antecedent. Statistics go to show, however, that the influence of syphilis in this connection is less than that of alcoholism. When tuberculosis attacks a syphilitic it does not result in a mixed lesion. Each disease keeps its own proper sphere, and the author quotes cases in which the same lung showed tuberculous nodules at the apex and syphilitic nodes at the base. If the patient is already in an advanced stage of tuberculosis an intercurrent attack of syphilis will hasten the fatal issue. Sergeant believes that the engrafting of syphilis upon a tuberculous patient hastens the beneficial tendency to sclerosis. He says that this can only happen in the tertiary stage, when the patient has already passed through the earlier phases of the disease. Speaking generally, the advent of tuberculosis in the case of a person passing through the secondary stage of syphilis carries with it a bad prognosis, frequently resulting in a galloping consumption. The tendency to sclerosis, however, in later syphilis delays the progress of tuberculosis, and the existence of a high arterial tension in tertiary syphilis is also of favorable import. The treatment of a patient with these two diseases running concurrently raises some important points. The evidence goes to show that treatment by mercury is not, on the whole, contraindicated by the existence of tuberculosis. In this connection the author discountenances the giving of mercury per oram. He advocates daily injection of a soluble salt of mercury, such as the benzoate or biniodide. The ordinary regional treatment of tuberculosis is also, of course, carried out.—*Charlotte Med. Jour.*

THE HARD CURDS IN INFANTS' STOOLS.—During the past few years the hard curds sometimes present in the stools of infants fed on cow's milk have been the subject of a number of interesting contributions. Previous to this time, these hard whitish or yellowish masses were supposed to consist mainly of casein which had escaped digestion. Mainly on the basis of metabolism experiments which demonstrated the ease with which



infants can digest the casein of cow's milk. Czerny and Keller concluded that these curds were not casein at all but consisted of soaps or fat. Later, Southworth and Schloss, Talbot, and Selter showed by chemical analysis that although these masses contained varying quantities of fat derivatives (neutral fat, fatty acids or soaps), they also contained a considerable amount of protein which was apparently casein. Opposed to this view were Meyer and Leopold (voicing the opinion of the Finklestein School). They claimed that whatever protein was present in these curds was derived from the intestinal secretion and not from the milk ingested. This point was finally settled by the experiments of Talbot, who demonstrated by the precipitine test that the hard curds did contain casein. Other investigators confirmed these results by means of the anaphylactic test. From the results of chemical analyses and metabolism experiments, Courtney (*American Jour. Dis. Children*, 1912, iii, 1) concludes as follows: 1. The hard or casein curds represent remnants of food, principally of protein nature, that have escaped digestion. 2. The exact mechanism of their formation as yet cannot be ascertained and they should be regarded as a peculiarity appearing in course of imperfect conditions of digestion. 3. The curds are not pathognomonic of any definite pathologic condition. 4. The loss of food occasioned by their formation and the impairment of general nutrition resulting from it is insignificant. 5. In attempting to correct the state of digestion one should be guided by the general rules of infant feeding, paying only secondary attention to the appearance or disappearance of curds from the stools.—*Charlotte Med. Jour.*

OBSERVATIONS UPON NERVOUS MANIFESTATIONS IN THE RHEUMATISM OF CHILDREN.—Poynton (*British Journal of Children's Diseases*) believes that the nervous symptoms in rheumatism are the result of either a local infection in the nervous centers, or of a general toxemia, the former being the more important. It is suggested that a bacterial poison may vary according to the anatomical structure which the organism inhabits and that perhaps we are dealing with the same organism exhibiting different metabolic processes under different conditions. Such thoughts are strongly suggestive in view of the fact that the pleura and pericardium are so frequently affected and the peritoneum and pia so rarely. The micro-coccus soon loses virulence on agar agar and retains it much longer on fresh blood agar. The tubercle bacilli and other organisms show similar peculiarities. The very common phenomenon, chorea, and the rare one, hyperpyrexia, in their relation to rheumatism have been studied with some completeness. Statistics covering a period of eleven years form the basis of this paper. Chorea usually develops before puberty and is infrequent after that period. It is to be inferred that the brain at that time develops a greater resistance to the poison. Females are much more susceptible than males, due, perhaps, to some mysterious peculiarity of female metabolism.

The onset may be abrupt or very gradual. The insidious cases show early signs of rheumatic cerebral disease and may only after weeks show the obvious chorea. The warning symptoms are nervousness, headache, excited imaginations, night-terrors, irritability and fidgetiness. A sudden

shock may precipitate the chorea. This brings to notice a great gap in our present knowledge of the relative parts taken by the infective agent and by the toxins. Clinical study seems to justify the presumption that they vary in different cases.

Chorea and epilepsy are associated and not interdependent cerebral lesions. Mental defects seem, however, to follow the onset of chorea or to be associated with it. After the attack there often remain definite nervous conditions of the child, such as extreme nervousness and irritability, stammering or entire inability to speak for a time.

Pathologically, as elsewhere with rheumatic lesions we get two classes of change, the vascular and inflammatory type, and minute areas of softening.

In an analysis of 500 cases the author has included 225 which came to him with chorea as one or the only symptom, thus assuming them rheumatic. Of the 225, heart lesions and in many cases other rheumatic symptoms were obvious in 122; 28 more were suffering from rheumatic arthritis and pains. In 22 other cases there was dilatation of the heart with no other signs of the rheumatic state. Among the 67 cases not rheumatic, 15 gave a history of fright, and seven suffered later from rheumatic heart disease.

In ten cases chorea directly followed a sore throat; in 19 there was a history of rheumatic fever in the family.

In considering the treatment the author impresses the fact that chorea is most uncertain as to duration and response to drug treatment. Six weeks is a short time in which to effect a cure. In general, the aim should be to destroy the infection and build up the nervous system. For early and mild cases salicylate of soda combined with bromids in moderate doses; physical and mental rest with special variations in some cases; warm packs at night are very often soothing. For the worst cases the author prefers chloral and bromide, or trional. Chloretone and antipyrin are also suggested. If one fails, it is well to try another. It has been found that some cases have been relieved by lumbar puncture. The diplococcus has been recovered from the fluid. Arsenic is suggested for cases with normal temperature.

**HOOKWORMS, DRUGS FOR THE EXPULSION OF.**—Observations were made under the supervision of the author to ascertain the efficiency of various drugs in removing hookworms. A careful examination of the stools and enumerations of all hookworms expelled in each case were made. The subjects under observation were Indian immigrants into Natal, and numbered 83. Eucalyptus, izal, pelletierine tannate, thymol, and beta-naphthol were the drugs employed, each individual receiving repeated treatments with one of these until no more hookworms were expelled. The men were given a light meal of sago for their last repast on the day preceding treatment, and on the same evening an aperient consisting of six drams of magnesium sulphate. Thymol and beta-naphthol were each given in three doses of 30 grains each at intervals of two hours, followed, again in two hours, by 6 drams of magnesium sulphate. These two drugs proved about equally effective, the proportion of hookworms expelled by the first treatment being, respectively, 97.87 and 97.52 per cent. The thy-

mol treatment, however, using a total of 90 grains of the drug, was found to cause a serious constitutional disturbance. Stimulation of the nerve-centers was at first evident, the individual being excited and talkative, and the pulse and respiratory rates quickened. Subsequently dizziness and drowsiness were complained of, and if the patient was not kept recumbent some syncope might be exhibited. Under the 90-grain beta-naphthol treatment two of the men merely complained of slight nausea and a sensation of warmth in the epigastrium. There was no excitement or exhilaration, and faintness never developed to any alarming extent. The author considers that beta-naphthol is equally as effective as thymol, but is superior to it in causing comparatively little general disturbance, and in costing much less. A 60-grain beta-naphthol treatment also proved fairly effective, the first treatment expelling 86 per cent. of the parasites present. This drug was given in the following form: Beta-naphthol, 4 drams (16.0); mucilage of tragacanth, 1 ounce (32.0); peppermint water, to make 6 ounces (192.0). The beta-naphthol was first carefully triturated and the mucilage and water then added, the resulting mixture containing the drug in suspension.

Oil of eucalyptus, given in the dose of 2.5 Gm. (38 grains) along with chloroform and castor oil, expelled 74.2 per cent. of the parasites at the first treatment; izar, given in 4-dram doses with chloroform water, expelled 90 per cent., while pelletierine tannate, given in 12-grain doses, proved absolutely inert, not a single hookworm being expelled by two doses from ten men in whom beta-naphthol subsequently led to the expulsion of numerous parasites.—*Burton Nicol (Journal of Tropical Medicine and Hygiene, January 1, 1912).*

CASES OF TRACHOMA TREATED BY THE JEQUIRITY METHOD.—The author reported the histories of four cases of trachoma treated with jequirity. The results of the treatment in all cases have been good, in one case the result was most brilliant. In all cases the improvement continued for many months. The first case was a woman 30 years old who had trachoma for a number of years and had been treated by a number of oculists in the usual way with but little success. When first seen there was an extensive bilateral pannus and a number of trachomataus ulcers of the left eye and one large ulcer in the center of the right cornea. He usually treats the eye about five o'clock in the evening so that by the following morning some results are observable. If no inflammatory condition is manifest, the jequirity is repeated the next morning. The lids are enormously swollen and the discharge very profuse. Great care is taken in washing the eye thoroughly every hour; at first applications of cold for about twenty-four hours, and then applications of hot water for two hours at about twenty minutes at a time, until the swelling and inflammation have subsided. The subsidence of the inflammation and swelling continues for about a week, and at the end of another week the lids are practically normal, the cornea becomes quite clear and the improvement in vision was commensurate with the results.—*Dr. C. W. Hawley, Annals of Ophthalmol.*



# Monthly Retrospect

## OF HOMOEOPATHIC MATERIA MEDICA AND THERAPEUTICS

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CONDUCTED BY A. LEIGHT MONROE,

Miami, Florida.

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**SENILE PRURITUS VULVAE.**—By. Homer I. Ostrom, M. D., New York.—One of the most distressing gynecological affections of advancing years is pruritus vulvæ. In its extreme form the patient is almost maddened with the itching, which deprives her of rest during the day and of sleep at night. The irresistible desire to relieve by scratching denudes the parts of their protective epithelium, setting up a train of secondary symptoms that reacts upon the nervous system and if not relieved reduces the sufferer to the condition of a physical and nervous wreck.

The cause or causes of the malady are obscure. If they cannot be traced to an irritating genital catarrh alteration of the urinary constituents or diabetes, we must seek the etiology in the trophic changes that belong to general decay or a vicious metabolic cycle that interferes with the normal folding up of the reproductive organs.

In the treatment we will of course consider the cause and apply our remedy to its removal. General system building may be, and frequently is, called for, for these patients are usually below par, and their assimilation is either vicious or imperfect. Out of door life, is careful regulation of diet, attention to the alimentary function and stimulation of the eliminating organs are of primary importance, and will receive our earnest consideration. Dynamic medication cannot be dispensed with, neither can we bring to a successful issue these cases if we neglect local treatment. The former alone will here concern us.

*Alumen* will be thought of when the irritation involves the vagina, and is accompanied with the characteristic constipation of this drug—inability to express the feces because of dryness of the rectum. Another valuable indication for alumen is an iridescent film covering the urine.

*Ambra Grisea* is another valuable remedy for senile pruritus. It is especially adapted to cases of general senility; old age is the keynote for this sperm whale product. An additional indication is a pseudo-sexual craving that manifests itself in a desire to be examined, and a certain gratification derived from an examination.

*Angustura* will sometimes render good service when there is a catarrh resembling milk, and the labia are covered with burning pustules.

*Antimonium Tart.* also causes pustules on the labia, with violent itching, but the discharge is characteristically sanguineous, and is liable to be the expression of some deep-seated tissue change in the vagina or the uterus.

*Carbo Animalis* I have occasionally found useful when there are varicose veins of the external genitals; the veins of the vagina may also be relaxed and varicose. It frequently affords great relief in the pruritus that attends malignant diseases of the uterus. The odor of the discharge is foul and excoriating.

*China Officinalis* will be found useful in the pruritus of women who have passed their climacteric, in which there is profound exhaustion from loss of the fluids of the body or from the lack of nourishment. There is mental apathy and disinclination to any exertion, mental or physical.

*Collinsonia Canadensis* is to be thought of for women who suffer from pruritus during the climacteric and following its close when there is marked pelvic congestion and hemorrhoids. The *Collinsonia* patient is not generally senile, but retains her physical and mental vigor even with advancing years.

*Conium Maculatum*. The itching and sensitiveness of the vulva are parts of a general degenerative process that manifests itself in induration of the cervix uteri and the breasts. There is an acrid, burning catarrh that proceeds from the cervix, with characteristic local stony hardness. A history of suppressed sexual desire—especially in widows, even though widowed for years—will be an additional indication for *Conium*.

*Curara*. When the pruritus involves the vagina and can be traced to a discharge from an ulcerated uterus, this remedy should be thought of. The ulcer is characteristically funnel-shaped, deep and purplish, and irregular in outline. The vagina is red and its corrugations tumefied. The leucorrhœa is thick, purulent and of foul odor.

*Ferrum* and *Ferrum Iodatum*. The patient is weakly and delicate, but her face is frequently flushed, while her feet and hands are cold. With the iodatum there is a catarrh that resembles boiled starch that causes burning and itching wherever it comes in contact with the skin. Old women whose vaginæ are anæmic, but with small hemorrhage spots under the mucous membrane, and who suffer from prolapsus of the uterus, are especially subjects for the iodide of iron.

*Fluoricum Acidum* is adapted to the pruritus of women who are prematurely senile—the opposite of *conium*—in whom the climacteric has passed too early, but in whom the sexual nature has rather increased than decreased with the folding up of the reproductive function.

*Graphites*, while not especially adapted to old age, will occasionally be found useful in senile pruritus when the vulva is covered with vesicles and is œdematous. The eruptions are moist and the discharge is very excoriating. The vaginal lymphatics and follicles are swollen. The skin cracks easily and is difficult to heal. The *graphites* patient tends to obesity.

*Hamamelis* will be thought of when varicosity is a marked concomitant of the pruritus. The vulva and vagina are varicose, and with this condition of the veins there is extreme sensitiveness and spasmodic contraction of the sphincter vaginæ.

*Helonias Dioica*. Intense pruritus with a curdy secretion from the vulva. Aphthous vaginitis with erythema. Labia hot and swollen, relaxation of the vagina and the uterine supports inducing prolapsus. There is frequently with the pruritus a profuse watery leucorrhœa. *Helonias* is

suitable for women who have become enervated from a life of luxury, and are soft mentally and physically in consequence.

*Hydrastis Can.* The pruritus of golden seal is secondary to the stringy ropy leucorrhœa that has its origin in some uterine pathology. The cervix is ulcerated or very frequently destroyed with epithelioma. I know of no remedy from which more can be expected in the senile pruritus that attends cancer of the uterus than *hydrastis*, used locally and internally. As an application to the vulva, I prefer the fluid extract or a dusting powder composed of one part of *hydrastis* to three parts of zinc stearate.

*Mercurius* will be thought of more for its general indications than for any characteristic of the local pruritus. It is a remedy that suits well the diseases of old age, and is adapted for light-haired persons, with lax skin and muscles. The digestive functions are depressed. The eruptions are moist and the secretions are foul smelling. Cold and cold bathing notably aggravate all the symptoms of *mercurius*.

*Murex Purpura.* The change of life rather anticipates senility, but frequently conditions that develop at that period are carried over into actual old age. Just here *murex* will be of service and will greatly assist in controlling senile pruritus. A general pelvic engorgement—characteristic of *murex*—with great sexual excitement and pruritus vulvæ at the change of life may continue beyond the completion of the folding up process. In this ensemble *murex* will be thought of and will almost always afford relief. It is rather characteristic of this drug that whatever mental condition may be present is relieved by a return or increase of the leucorrhœa.

*Muriatic Acid.* I find among my clinical notes "intense pruritus in a patient aged 65 years, intense sensitiveness of the external parts to such a degree that she cannot bear to be touched with the clothing," promptly relieved by *muriatic acid*. Other symptoms probably lead to the selection of this remedy, but are not noted in my case book.

*Natrum Muriaticum* will occasionally be indicated in senile pruritus. There may be a history of previous gonorrhœa, possibly suppressed. The skin generally is unhealthy looking, herpes circinatus blisters, containing yellow water, appear suddenly. There is a tendency to excoriation of contiguous parts, which burn and smart. With the pruritus there is falling off of hair from the mons veneris.

*Nitric Acid.* I have sometimes been led to prescribe this remedy with benefit for the pruritus of old women of rigid fiber who suffer with chronic diarrhœa. The *nitric acid* patient is never constipated. Senile pruritus at times taxes our utmost resources to find a simillimum, and a single characteristic symptom, as "chronic diarrhœa," may lead to the selection of the curative drug.

*Nux Vomica* is not peculiarly suited to old age. Pruritus vulvæ is not marked, but when present, together with the characteristic mental condition of extreme hyperæsthesia and constipation from defective peristalsis, etc., will be thought of. The *nux vom.* patient is choleric, irritable, of vigorous habit and tense fibre.

*Origanum.* The pruritus vulva is well marked, but the characteristic indication for sweet marjoram is the most intense sexual excitement, especially in old maids and widows. I know of no remedy that will so well



allay this distressing and disquieting mental state. Drop doses of the tincture will give the most satisfactory results.

*Platinum.* An arrogant self-esteem with contempt for others always suggests *platinum*. If to this is added intense sexual excitement without the desire or inclination for natural gratification, and excitement that seeks dalliance only, and pruritus with extreme sensitiveness of the genital organs, this drug will be found most useful.

*Sepia*, though not generally associated with the ailments of declining years, nor notably causative of genital pruritus—though this symptom does occur in some of the provings—will be thought of when there are many other symptoms connected with the reproductive system in patients of an easy disposition with dark hair, who take cold easily and are inclined to bear their sufferings without complaint. The *sepia* patient is very conscious of her disabilities and mentally may be prone to exaggerate them, but she is at the same time reticent and endeavors to conceal her feelings from others. She, however, desires their sympathy, even though it is unsought. A marked concomitant symptom of the *sepia* patient is a steady pain over the left eye, which may be confined to the point of exit of the supra-orbital nerve.

*Sulphur.* Chronic cases of senile pruritus will almost certainly in the course of their treatment require *sulphur*. I think of this remedy when the itching is especially in the region of the clitoris and the mons. There is an excoriating, irritating leucorrhœa, the parts over which it flows bleeding easily. The digestion is liable to suffer, being slow and accompanied with fermentation. Besides the pruritus vulva the skin in other regions may be unhealthy, cracking and bleeding easily. All the symptoms of the *sulphur* patient are aggravated by bathing, whether the water is hot or cold is immaterial.

*Sulphuric Acid.* Pruritus vulva, the parts becoming dark from venous stasis. This is one of the most useful remedies for senile pruritus. The general condition and appearance of the patient indicate physical and mental decay. The characteristic pains of *sulphuric acid*, increasing slowly, disappearing suddenly, when present will be an additional indication for the use of this remedy.

*Tarantula.* The general condition of the patient will suggest this remedy for senile pruritus of the vulva. Hysteria, nervous excitement, physical restlessness, impelling constant motion, are characteristic of *tarantula*. The pelvic symptoms are all indicative of congestion, with excitation of the sexual organs. After the natural age decrease of sexual desire it returns with almost uncontrollable vigor. Widows, advanced in years, long past their climacteric, who marry again, usually men much their junior, are suitable subjects for *tarantula*. These suffer from intense pruritus vulva, which is aggravated by coitus. Uterine hæmorrhage is very liable to follow coitus without the presence of any pathological condition of the uterus. With the pruritus there may be a granular vaginitis with marked congestion of the mucous membrane.

*Zincum* is not especially adapted to senility but will occasionally be found useful in senile pruritus with the concomitant symptoms of intense sexual excitement and desire at night, with inability to keep the feet and legs quiet in bed. "Fidgety feet" always suggests *zincum* to me.—(*Homœopathic Recorder*, February, 1912)

**LOCOMOTOR ATAXIA.**—*Cicuta*. Jerking and sticking pains in the arms and fingers; jerking, burning, sticking pains in lower extremities; drawing tearing pains in the muscles of the neck and back; tearing jerking pains in the coccyx; sticking constricting pains in the chest so he can scarcely breathe; involuntary micturition; dribbling of urine; difficult urination at night. Used in 6th.

*Actea Racemosa*. For the "lightning like pains" of the disease such as: drawing tensive pain at points of the spinous processes of the upper dorsal vertebrae; twitching in fingers and toes; electric pains in paroxysms shooting through neck and head; drawing pain along the spermatic cords; lancinating pains along the intercostal nerves. 3rd to 6th.

*Causticum*. Chiefly for the bladder troubles. Micturition so easy that he is not sensible of the stream; involuntary micturition while coughing or blowing the nose; involuntary micturition at night while asleep; intermittent micturition during the evening; frequent urging to urinate with necessity to wait a long time; then scanty urine followed by more urging; frequent ineffectual urging, then while sitting involuntary voiding of urine; ineffectual attempt to void but finally after passing a few drops has severe cramp like pains in the bladder and rectum; frequent sudden pressing, piercing pains in the rectum; stools passed better when standing; also pains, weakness and stiffness in the extremities. *Causticum* 30th.

*Alumina*. Twitching pains through the body on attempting to rise; arms and head jerked backward; lightning like pains in shoulders, back and abdomen followed by a sore, bruised feeling; weakness; faintness; weariness; tremulousness; a drawing, tensive feeling of cheek and skin as if covered by cobwebs or the white of an egg, rectum seems paralyzed; constricted feeling during stool, excoriated feeling after stool attended with contraction of the rectum and constriction of the anus; sensation in the lower vertebrae as if a hot iron were thrust through; heaviness in the lower extremities with staggering in evening; heaviness and weariness of the legs when sitting; skin dry; appetite poor. 30th and 200th.

*Plumbum*. Wandering pains in all parts of the body which often change in character and location. We find such expressions as the following: "Shooting through the whole body"; "Sharp pains in the trunk and limbs"; "Tearing," "tingling," "bruised," "paralyzed"; also "pain in paralyzed parts" then "weakness"; "faintness," "trembling," "aching," "contractions." In the abdomen we have "retraction," "rumbling," "distention," "tightness," "as if tied with a rope." The stools are dark, small, hard. "Constipation with the sensation as of a string pulling the anus up the rectum," also with terrible spasm of the rectum, the pains running down the muscles of the thighs and to the naval. "Micturition difficulty, drop by drop." "Urine scanty and dark"; also "retention of the urine due to paralysis of the bladder"; "terrible neuralgic pains especially in the muscular parts of the thighs, worse at night, the greatest palliative we have. 30th to 1000th.

**PHOSPHORUS**. Disturbance of the sexual function may be the first symptom to attract attention. In phosphorus we have "irritation followed by relaxation"; again "frequent and painful erections day and night"; followed by "ineffectual erection during attempt at coition"; also "desire, extreme with feeble erections then desire disappeared and erective powers

left him." Phosphorus has the urinary troubles often found in disease: "Spurting of urine when coughing or sneezing," "dribbling of urine" and "involuntary micturition"; but it is for the later stages we find it most useful in checking the degenerative processes.

Phosphorus has burning in the spine; soreness of the spine; feeling of a tight band around the body; weakness both mental and physical; numbness and trembling of the limbs; staggering gait.

I do not claim that phosphorus will cure at this stage but it will retard the disease and palliate suffering. 30th to 200th.

**Zinc Phos.** Lightning like pains in various parts of the body; entire spine sensitive, worse sitting still and from stimulants; sticking pains in the back when sitting and walking; burning pressure upon spine above small of back: drawing, cutting, sticking pains in the dorsal region; tearing, drawing bruised pains in the extremities, also weakness and stiffness; micturition slow and in a small stream; micturition involuntary at night; can urinate only when sitting; drawing pain in testicle and spermatic cord; seminal emissions at night without dreams; involuntary micturition and soft, liquid stools alternating with retention and hard, dry stools; sensation as if insects were crawling over feet and legs preventing sleep; melancholia; the patient slowly becomes more apathetic and stupid. Use 3rd to 30th.

**Argentum Nit.** Melancholia, fears he is the victim of some incurable disease; anxiety followed by great weakness accompanied by a debilitating diarrhoea; suicidal tendency; sensation as if bones of the skull were expanding (separating) relieved by binding the head tightly; sensation of fulness through the entire body; weakness and trembling of lower extremities; great flatulency with distention; heaviness, trembling and stiffness of the extremities; also general weakness. The keynote to the mental symptoms is: "He does not undertake anything lest he should fail." The "craving for sweets" is the marked gastric symptoms of the group. Tremulousness and expansion are the two characteristic sensations. Use 30th to 1000th.—*George Royal, M. D., Iowa Hom. Jour.*

**APOCYNUM IN HEART DISEASE.**—Dr. Wm. M. Gibson, in the *New York State Journal of Medicine*, praises this drug as follows: "Of the treatment of dropsical effusions and general anasarca much might be said if time permitted, but I want especially to call attention to the efficacy of one drug in the treatment of this distressing and often obstinate symptom, apocynum cannabinum. From no other remedy have I obtained such marked relief in the various degrees of dropsy as from the use of a reliable preparation of this common herb. An infusion of the fresh roots gives us the full medicinal value of the drug, but the fluid extract may be used when the roots cannot be obtained. If the fluid extract is employed it is advisable to give it in capsules, filling each capsule at the time the dose is to be given; its exceedingly bitter taste can only be covered in this way. Its action is exerted on the heart muscle and is also markedly diuretic; it carries off large quantities of water through the bowels, and this, too, without any serious disturbance of digestion or the depressing and exhausting effects of powerful cathartics. While numerous references to its value in dropsy have been made of late, it is an old remedy and one well worthy of trial in the treatment of the frequent complication of cardiac insufficiency."



# THE HAHNEMANNIAN MONTHLY.

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## THE CONSIDERATION OF A FUNDAMENTAL OF OUR THERAPEUTIC ART.

BY

O. S. HAINES, M. D., PHILADELPHIA.

(Read before the New Jersey State Society at Atlantic City, May 9, 1912.)

THAT particular method of drug selection, usually described as the method of similia, has for its ultimate object the administration of what has been termed "the similimum." It is one of the peculiarities of this method that its ultimate object can seldom be obtained in a hasty, slipshod or haphazard manner, but is usually the result of a definite, more or less uniform procedure entailing painstaking effort. This procedure might be described under the two distinct headings: 1. The taking of the case. 2. The selection of the remedy. The selection of the remedy is sometimes possible after a simple perusal of a well-taken record; but, more often it requires, in addition, what we term "the repertorial study of the symptom picture of the patient and his disease."

There is little doubt in my mind but that success in the practice of the therapeutic art, according to the law of similia, depends largely upon our recognition of the fundamental necessity for this repertorial study, in important and complicated cases of sickness.

What we shall have to say at this time, relates solely to the selection of a remedy according to the index of similarity. There are many other methods by which helpful remedial agencies for the sick and injured may be successfully determined upon, but these shall not concern us for the moment.

The topic, "Specializing in Therapeutics," is a most interesting one and I hope to take that up more fully at some future time. There does not seem to me to be the slightest reason why a man should not become a specialist in therapeutics; providing his point of view is a rational one. He may elect to treat his patients with electricity and nothing else. He may elect to use nothing but vaccine therapy; he may even decide that he will use nothing save the mechanical methods of osteopathy, or he may decide that he will select his remedies solely according to the index of similarity, discarding every other method of drug selection. But, if he does, his point of view *must be a rational one*. By which I mean, he must be very careful to limit the cases which he accepts to those which are unquestionably suitable, which are unquestionably cases likely to prove amenable to the limited therapeutic measures his specialty, or any specialty in therapeutics, necessarily has to offer them.

The moment a specialist in therapeutics adopts any other course, the moment he puts forward a claim of universality, the moment he accepts all sorts and conditions of sickness, claiming that the limited therapeutic resources of his specialty are all sufficient; that moment he becomes a ridiculous spectacle.

The medical man of to-day is, as a rule, too broad minded to look with favor upon the specialist in therapeutics, unless the latter be a man with a very rational point of view; and such men are unfortunately exceptional among the class known as therapeutic specialists. But all this relates to another occasion, and we must stick to our text. I have mentioned these things because I believe they explain why so few of our school really wish to be classed as "specialists in therapeutics," and why so few of our school are willing to limit their therapeutic resources to similia alone. They do not wish to become lopsided physicians; nor to meet the tremendous demands of an active practice with limited and restricted therapeutic resources. Now, without intention to offend, we do not think that all have met this problem squarely, nor solved it correctly. That wise man, Samuel Hahnemann, with his clearer vision and broader view of such things, insisted that a physician *must* investigate every case of illness in such a manner that he will know whether the case requires surgical measures for its relief, or mechanical measures, or hygienic correctives, or the removal of an active ætiological factor; or, whether it is a case that may be

safely left to the internal medicament alone. It would seem that he rather expected that physicians practicing the method of similia would ascertain what there was in a case to be cured; and, would exercise judgment and common sense in deciding how far the curative powers of internal medicaments might be trusted. This sort of investigation and these conclusions he advised should precede the administration of the selected medicament. In the second place, Samuel Hahnemann insisted that the physician must exercise similar judgment and discrimination in the selection of the remedy that he prescribes for his patient; preferring always a curative remedy, one that bears a relationship to the case in its totality rather than a mere palliative or a remedy for a single symptom of the case.

There is nothing inimical between the correct analysis of a case from a clinical standpoint and its correct analysis from the therapeutic standpoint. They are the two halves of a perfect whole. The homœopathist becomes lopsided only when he is satisfied with either half. The occasions upon which we shall suffer from "restricted therapy" will be few, if we follow Hahnemann's instructions and if we really adjust our remedies to our cases as he taught. The principal critics of the repertorial assistance to a proper adjustment of remedy to case, are the men who are "so busy" and the men who have "no time." These are they who, in reality, suffer from a restricted therapy; but, they do not realize that fact. Any homœopathic physician who does not use the repertory at least to some extent, must necessarily fail to get the best out of the method of similia. We are very optimistic in our feelings concerning homœopathy and the homœopathic profession and we know that whether the majority use or do not use the repertory, nevertheless the majority believe in the worth of the index of similarity as an aid to the selection of remedial agencies for the sick. They believe in it simply because it is a method having such a wide range of applicability and because it is so successful. The use of the repertory is, however, a fundamental consideration, and it does not pay to neglect the fundamentals.

I have some good reasons for thinking that not more than twenty-five per cent. of the prescriptions we make according to the index of similarity, without the assistance of what we have termed the repertorial method, would prove, upon careful analysis, to be the true homœopathic similimums for the cases.



Try to verify the statement before you denounce it absolutely. The simple fact that benefit follows a prescription selected, without the assistance of the repertory, does not prove that it was the remedy most suitable for that case. It only proves the great utility of a method of drug selection that renders any medicine helpful so long as that remedy bears a somewhat homœopathic relationship to the morbid condition to which it is applied. There is, however, an important distinction between a helpful remedy and the curative similimum properly selected and accurately applied, and the difference in the results ought to appeal especially to those physicians who are busy and whose time is so thoroughly taken up with the other details of practice.

I had the pleasure recently of listening to several most excellent addresses upon the subject of the repertorial method of selecting the remedy. To my amazement, many gentlemen in the audiences expressed surprise that such an important subject had never been brought to their attention before; and, welcomed the addresses as throwing a new light upon the work of drug selection.

At first sight one might almost conclude that such a fundamental of our practice as the repertorial study of the case, was unknown to a considerable number of our practitioners; but such cannot possibly be true. It must be true that many homœopathic physicians use the repertory constantly—always in important cases, often in those that are what is known as simple cases of illness.

Because otherwise one is forced to the conclusion, if my earlier statements prove to be correct, that not many homœopathic physicians are prescribing similimums for their cases. So I determined to present this important matter to some representative body of homœopaths for discussion, and your meeting has afforded me the opportunity.

Now, if you will permit me to express my own opinion first—it appears to me likely that it is not so much that we do not use our repertory often enough; but that when we do use it—we use it in a faulty manner.

And I would like to go a little further to express the opinion that if we might judge from the discussions of the matter to which I have already listened;—the faults are very simple ones, and that they are most easy of correction, if we wish to acquire a better technique. Perhaps, in a bureau like this,

much benefit to all of us would follow a rather free discussion of this important subject—the repertorial study of the case. Patients apply to their physicians complaining, as a rule, of two kinds of symptoms; particular symptoms and the concomitant symptoms. That is of particulars and common symptoms.

The particular symptoms complained of are those which seem to point directly to some sort of disturbance or some diseased condition in some particular organ or locality. The concomitant or common symptoms are usually so ordinary, so universally present in all patients, so usual and easily explained that they can not be used in the art of selecting a remedy. Now the commonest illustration that comes to my mind is this one: A patient comes to you complaining of a severe stabbing pain in the back of his neck. You look at the region indicated and find a great boil. You squeeze the boil and he shouts. The aggravation and pain on pressure is a concomitant that is perfectly valueless because it is too common.

These two kinds of symptoms then are the “presenting symptoms” you get at first from your patient, because he lays so much stress upon these as a rule. Dr. Cabot says in his work upon “Diagnosis”: the diagnostician does not reach his conclusions at once from the contemplation of such phenomena as the presenting symptoms; but, he must work backwards and inwards from these to the underlying disease which is beyond them. He does this by his methods of differential diagnosis.

The therapist likewise, selecting his remedy according to the index of similarity, does not jump to any therapeutic conclusion simply from a first glance at these presenting symptoms, because they consist mainly of particulars and common symptoms and these have not been found to be the best road nor the easiest road to the similimum for the sick man. But, from these symptoms he should work backwards and inwards too, until he reaches and obtains those deciding symptoms which are so essential. Then, his work is not so different after all from the differential diagnosis of the clinician.

It is sometimes astonishing how much time the diagnostician spends upon his investigation of disease; how much patience he shows, how much skill he brings to bear in the performance of his diagnostic feats. And sometimes I think we may sense the disproportion that exists between the efforts put forth in arriving at the diagnosis; and, the efforts put forth in selecting the

proper remedy for the sick man. And, after all the finding of the proper remedy is just as important, or even more important, than the correct diagnosis.

Now we are not going to say that one can never reach a helpful remedy by a study of these presenting symptoms—that is the particulars and the common symptoms—alone; because occasionally one can; for the reason that occasionally the diseased condition is a simple one and occasionally the particulars are very distinct. By which we mean, are very unusual, peculiar, characteristic and well stated.

In the same way the diagnostician occasionally makes his diagnosis at once from the presenting symptoms, because they are occasionally—pathognomonic of one disease and that alone, but not often.

But in the great majority of instances what the therapist gets from his study of particulars and common symptoms alone, is merely a helpful remedy—not the similimum. Now the repertorial study of the case is supposed by many to be a very complex matter, but really the fundamentals and essentials are simple enough; neither do they take more time than the important case deserves and pays for.

Having reached the conclusion then, that it is necessary to obtain from the patient another class of symptoms of greater value and of greater utility in the selection of the remedy, we proceed to the study of what have been termed the distinctive or the individual or, again, the general symptoms of the patient. Some of these have already come out as the patient presented his case. Perhaps not many, but a few. The rest we bring out by that peculiar art known as cross examination which is different from the art of the lawyer in that we wish to have our patient speak as he feels, not as we wish him to feel.

There are many types of distinctive or general symptoms, all of which indicate or point out the individual peculiarities of the patient. Examples of great importance are: The mental symptoms, his anxieties, fears, desires, aversions, delusions, delirium, temper, mental capacity, memory, moods, and so on. Then there are the prominent peculiarities of the patient that manifest themselves when the patient is subjected to varying external circumstances, such as motion, rest, sitting, standing, dampness, cold, storm, heat, pressure and all the rest. In fact,



anything that seems distinctive or peculiar to the patient as a whole.

Sometimes we can get only two or three of these distinctive personal peculiarities, but even so you will find it so much better to consider these few symptoms *first* in your repertorial study of the case.

Indeed, it is not unusual for the list of remedies that you have found to cover clearly and prominently the few general individual symptoms, or characteristics of your patient, to contain the exact *similimum* he needs.

Having pursued our study thus far, we believe *now* is the time to study the particular symptoms, present in the various localities of the body. Perhaps the error oftenest noticed, is our tendency to study these particulars of our record first or even to limit our entire study of the symptoms to particulars, the symptoms of the various localities. The result of such a method is generally uncertainty and confusion.

It is seldom necessary to study all the particulars of a case. Only the more prominent ones, especially the unusual ones, the ones that we recognize as rather uncommon in the disease of our patient. The striking ones with unusual modalities.

Often one may lay aside a number of the local particulars because they are so common, so pathognomonic of the disease, such as thirst in high fevers, increase of pain when an inflamed joint is moved, sensitiveness of an inflamed part to pressure.

Perhaps another common error is our tendency to make too much of such common, usual things.

It has been my almost uniform experience that the remedy covering the *most distinct* and the most important *general* symptoms of the patient or individual; and, which I have later found to also cover the *most prominent* and distinctly expressed *local* manifestations of his disorder, will be the remedy the patient is needing. Indeed, his very *similimum*.

The really important symptoms in repertorial study (either general, of the individual; or particular, of his different localities or organs) will be those which occur in the patient with a high grade of intensity, prominence and persistency. And of these prominent, persistent symptoms, the most valuable of all will be those which correspond to Hahnemann's ideals as described so well in paragraph 153 of the *Organon*;—those that are striking, singular, uncommon and peculiar; as opposed to the common, ordinary, commonplace ones.

**DRUG PATHOGENESY AND HOMŒOPATHY.**

BY

WM. A. SEIBERT, M. D., EASTON, PA.

(Read before the Phila. County Hom. Medical Society.)

THE symptom producing power of drugs is the basis of Homœopathy. If this property did not exist in drugs there would be no Homœopathy. That it does exist is easily demonstrated. There is difference of opinion as to what articles may be considered drugs, but the dictionary definition of a drug is that it is "any vegetable, animal or mineral substance used in the composition or preparation of medicines"; and medicine "a substance having or supposed to have properties that modify the morbid state." These comprehensive definitions allow no room for narrowness or disagreement.

Pathogenesis is defined in the dictionaries as "the mode of production or development of disease." The further definition of "disease" must be divested entirely of the idea of entity or material existence. If this idea, so fully discussed by Hahnemann in the *Organon* is not subscribed to, the subject of drug pathogenesis can not be considered. Even the homœopath is apt to forget that *simila similibus curentur* refers to symptoms and not to disease—totality of symptoms be sure, but not disease as an entity. Drug pathogenesis, from the standpoint of Homœopathy therefore refers merely to the symptoms drugs may produce.

The following subdivisions of our subject suggest themselves:

1. The production of symptoms by proving, by poisoning, or by overdosing.
2. Their day-book records.
3. Their compilation and schematic arrangement.
4. Their analysis and generalization.
5. Their repertory arrangement.
6. Their authentication.

**I. THE PRODUCTION OF SYMPTOMS.**

This is accomplished, as we all know, by giving the drug in all sorts of doses, dilutions and methods, and noting the resulting symptoms. This has already been done in the case of hun-

dreds of drugs, sometimes with the skill and under the direct supervision of a Hahnemann, then again unfortunately by many less skillful. The result we know—an immense accumulation of symptoms, many inaccuracies, and too abundant dress, with a generally bewildering and demoralizing effect. This result suggests the greatest work before the present-day homœopath. We refer to the authentication of the Homœopathic symptom. This subject was presented and a method outlined in a paper before the recent session of the American Institute of Homœopathy.

The quantity of material we do have to-day as a result of provings, is to say the least, appalling to contemplate. It is not complete for any one drug, and never can be, so that supplementary provings are laudable. The mine is inexhaustible. God's goodness is infinite. The term "reproving" is one we never did like, for it intimates doing the work better. An enlargement upon this phase would entail some odious comparisons, and efforts to supplant the excellent provings made by our illustrious predecessors will only bring Homœopathy itself into disrepute. We repeat, however, that supplementary provings, bringing into play also the wonderful advancement made in modern diagnosis, will in general add only a valuable appendix to what we now have.

## 2. THE DAY-BOOK RECORDS OF OUR PROVERS.

The compilation of these, in their original, is not only interesting but invaluable. The promptness and duration of the action of drugs; the different effects of the various doses upon various individuals and temperaments; the relations the drugs have for the various conditions and accidents of life; the most valuable modalities; and many more similar and equally important data are brought out by these note-books.

The day-books of our earliest provers are not extant, unfortunately, but Jahr, Noack and Trinks, supplanted later by Allen in his *Encyclopedia*, gave us such collections brought down to 1880. The "*Cyclopedia of Drug Pathogenesis*," completed in 1891, however, took the subject up in a thoroughly modern scientific manner, and is another one of the enduring monuments to Homœopathy. Its limitations may be disputed, and its rigorous censorship criticised, but what it does give can not be gainsaid.



The enthusiasm of its authors made them claim that by the "Cyclopedia of Drug Pathogenesis" "symptomatic prescribing will be just as easy, and far more rational, satisfying and successful." The extent to which the Cyclopedia has been adopted by the busy practitioner should be an indication of the truth of this claim, but its value to Homœopathy is indisputable even if the contention be not verified.

### 3. THE ASSEMBLING AND SCHEMATIC ARRANGEMENT OF THE SYMPTOMS.

The enthusiasm of the authors led them to say, in their preface to the "Cyclopedia of Drug Pathogenesis," that the "schema is quite unnecessary, that it fulfils no useful purpose and may be banished to the limbo from which it may be regretted that it ever arose." They, however, pointed out no harm done by the schema, and strenuous exception is being entered against this opinion ever since its utterance. The *Materia Medica*s published since this utterance (1885) have almost uniformly continued to adopt the schema, and the notable test proving by the O. O. and L. Society, published in 1906, elaborated both an anatomical schema and a physiological one. Without entering into a discussion of merit, it would seem an act of vandalism to "banish to the limbo from which it may be regretted they ever arose" the schema of our *Materia Medica*. They present a bird's-eye view, as it were, of the symptoms, and can certainly be more easily referred to than the note book records, even if well indexed. Is it not what you and I are apt to turn to first in looking up a case? Call it classification or indexing, it is not an unscientific procedure, and we prophesy it will endure despite the anathema of the "Cyclopedia of Drug Pathogenesis" authors.

### 4. THE ANALYSIS AND GENERALIZATION OF THE SYMPTOMS.

In this field the physiologists, pathologists and theorists may cavort to their heart's content. Some great laws of nature may yet be revealed, as well as more brilliant or barren reveries enjoyed, while analyzing and generalizing. It is only a pleasant department of drug pathogenesis, and it may be the most captivating method of starting the study of a drug and remedy. Hahnemann indulged in it in his introductory remarks to each

remedy, and few authors since Hahnemann have contented themselves with a recital of the bare symptomatology. It is the department that captivates the student and reader, it is this portion that makes a book more or less popular.

Analysis and generalization brings out the general characteristics of a remedy, the location and nature of its action, and its therapeutic range as well, the most valuable modalities, etc. Its full consideration would in itself furnish enough material for one large paper.

#### 5. THE REPERTORY ARRANGEMENT OF SYMPTOMS.

This comprehends more than the simple indexing of all the symptoms, or a complete concordance repertory, with cross references, like "Cruden's Concordance of the Bible," would be all-sufficient. The voluminousness of such a work complete can scarcely be realized, but the "Concordance Repertory" of merely the more characteristic symptoms, after considerable abbreviation and classification, required six royal octavo volumes, as published by Dr. Wm. D. Gentry in 1890. Such a complete repertory, however, is possible, but in our opinion not advisable nor practical until all *Materia Medicas* agree—until there is only one *Materia Medica*, as must be the case some day if Homœopathy is a science.

The most precious Boenninghausen's "Therapeutic Pocket Book" comes under this heading; the many special repertories, as of diarrhœa, rheumatism, neuralgia, obstetrics, urinary system, headache, etc.; even the clinical guides, in which combinations of symptoms are indexed and compared.

On the whole, such works possibly may result in positive injury, because they are apt to supplant the more careful study of the *Materia Medica*. They, however, are an immediate help in the needs of a practice for the selection of the proper remedy without too great a loss of time.

The detailed consideration of this subdivision, as you see, is not essential here, but like each one of these subdivisions of our subject affords material for a separate paper like the one prepared upon the last subdivision suggested, viz.:

#### 6. THE AUTHENTICATION OF THE HOMOEOPATHIC SYMPTOM,

And for this I can only refer you to the paper presented at the last meeting of the American Institute of Homœopathy.

In conclusion, we want to lay particular stress upon an error now being made, according to our view. In these days of research laboratories, endowed by millions of dollars, and in which so much interesting work is being daily done, they are not, to our knowledge, specializing beyond pure empiric experimentation. It may be for the purpose of evolving new laws, or it may be simply for accumulating more material. The laboratory hunt is still on for new drugs and combinations of drugs, but experimentation is rife with nosodes, sarcodes and sarcode derivatives. O! ye gods! Symptom producing is still secondary to disease curing in their investigations, with the exception of only an occasional emanation of Homœopathic proving from these laboratories. A science is such only by virtue of the possibility of analyzing, classifying and co-ordinating of facts. When will we have accumulated enough facts? When will the real science of Homœopathy be elaborated by methods that do not aim to rival the magnificently equipped laboratories of the old school? This vast field belongs peculiarly to Homœopathy, and is not being invaded, except by desultory incursions.

Sleep has been mistaken for death before.

Wake up, Homœopaths.

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### CINCHONA, FERRUM, AND ARSENIC IN THE ANEMIAS.

BY

WILLIAM H. YEAGER, M. D., PHILADELPHIA.

#### CINCHONA.

IN studying the homœopathic relationship of cinchona to cases of anemia, one must come to the conclusion that it belongs almost exclusively to those cases of acute secondary anemia which have been brought about by the rather sudden loss of large quantities of fluid from the body, as in a case of hemorrhage. In this class of cases the great keynote suggesting cinchona is *debility*. The symptoms produced are the result of *lowered blood pressure*, and most all of these symptoms can be relieved by the introduction into the circulation of normal salt solution. This fact borne in mind helps us to understand the differentiation of cinchona from ferrum, arsenic, etc.

We can readily recall patients who have had a severe hemor-



rhage, losing perhaps, from one to three pounds of blood. We find them more or less shocked. They tell us that they suffer with a painful, throbbing headache, as if the skull would burst. Cold sweat about the nose. Ringing in the ears. Vertigo when the head is raised, with a tendency to syncope. Hollow eyes. Blue color around the eyes. Black specks before the eyes. Blindness. Sallow complexion, or perhaps a red face. Labored, slow respirations. Small pulse. Hungry, but digestion slow, resulting in flatulence. Tympanitic abdomen. Undigested stools. Diarrhea. The microscopical characters of the blood may not be greatly changed, only a slight variation in the size of the red corpuscles, a little paler than normal, and some few showing a nucleus. There may be a slight leucocytosis. The essential change is in the *volume of blood* in the circulation and the resulting low blood pressure.

A case like this must, of course, be treated by rest and stimulation, and cinchona in small doses will prove to have a powerful tonic effect upon the patient. It will aid materially in the regeneration of the blood, and under its influence this process will go on with great rapidity. The watery and saline constituents of the blood will be readily restored by absorption from the gastro-intestinal tracts and the tissues, the red cells less rapidly from the spleen, bone marrow, etc., and the leucocytes from the lymph tissues.

The most valuable thing to remember is that while cinchona may be the indicated remedy in nearly 75 per cent. of these cases, still, there are times when another remedy will prove to be a more accurate prescription. In these exceptional cases, cinchona will fail to give you the hoped-for result. In order to acquire the masterhand in prescribing, we must resist the temptation of forming habits of depending upon one remedial agent for a diseased condition.

We will find some cases of acute secondary anemia requiring carbo veg., veratrum alb., or zincum, at times; in other cases, lachesis or phosphorus; sometimes, calcarea carb., natrum mur., or sulphur; and again at other times, arnica may be called for. Each of these remedies presents an interesting study for the man who will endeavor to find for each its exact sphere of therapeutic usefulness.

Some cases of symptomatic anemia are the result of long-continued drain on the albuminous materials of the blood, as in cases of chronic suppuration, kidney diseases, prolonged

lactation, rapidly-growing tumors, defective food supply, lack of air and exercise, and the action of certain poisonous substances. Under these conditions, cinchona holds but a secondary place, and remedies like hepar sulphur, echinacea, stannum, arsenicum jod., apis, plumbum, mercury, phosphoric acid, chininum ars., argentum nitricum, kali carb., staphisagria, and a host of others suggest themselves.

#### FERRUM.

Some men seem to think there is scarcely any limit to the amount of iron that a person can take without being harmed thereby. This is a grave mistake. I do not know of any drug that is more often mis-prescribed than ferrum, or one more often abused. Just as you can drown a person with too much water, or poison them with too much sodium chloride, or make them ill with too much of any of the organic or inorganic chemical constituents of the body, so with iron you can over-feed the tissues to such an extent as to produce symptoms of ill health.

If you will study the poisonous effects of iron upon the blood, you will probably find that its principal action is seen in the *reduction of the amount of hæmoglobin* carried by the red blood cells, and consequently, a radically lessened amount of oxy-hæmoglobin in the arterial blood; also, a lessened amount of carbonic acid carried in the venous blood, (quite a different condition from the one seen in the cinchona pathogenesis). The minor changes would consist of a possible reduction in the number of red corpuscles. These look very pale and may show some poikilocytosis. The leucocytes may show a slight increase in number. This condition of the blood is identical with that found in chlorosis.

Thus you see, the poisonous effect of iron is to make it impossible for the red blood cells to carry even a normal amount of iron pigment (hæmoglobin), and in this way the body is protected against further poisoning. Under these conditions, the iron in crude doses that you give the patient, simply serves to blacken his stools.

We must not confuse the effect of iron in material doses upon the patient whose blood is normal, with its effect upon the patient with chlorosis for example. In the first instance, it will increase the amount of hæmoglobin, stimulate the appe-

tite, augment the heart's action, and the body vigor, up to the point of the patient's tolerance, after which its effects are reversed. In the second instance, it cannot be carried by the blood and is thrown off as a foreign substance through the bowels.

Ferrum is the pathological similimum to chlorosis, and is more often indicated than any other one drug, but it must be used to get its *dynamic effect*, *i. e.*, selected by the homœopathic index of symptoms and used in a potentized form. Ferrum follows china well but cannot be used simultaneously with china. Ferrum is not the only medicine that may be called for in chlorosis. We must always differentiate pulsatilla, graphites, calcarea carb., and others.

#### ARSENIC.

The study of arsenic as a therapeutic agent in cases of anemia is an intensely interesting one but rather lengthy, and in this brief article we can only touch upon it.

The action of the drug upon the blood is obviously not to lessen the amount of plasma, as is the case with cinchona; nor to destroy the hæmoglobin carrying power of the red corpuscles, as we believe is the case with ferrum but rather to produce pathological changes in the red and white corpuscles themselves. A condition of defective hæmogenesis is one of the effects of arsenic, and the evidence of marked hæmolysis is very certain. The red blood count may be as low as 2,000,000 cells per cubic millimeter in chronic arsenical poisoning, but the relative percentage of hæmoglobin is normal or perhaps slightly increased (the opposite to iron). This condition is identical to that found in cases of progressive pernicious anemia, and explains why arsenic often helps, and sometimes cures cases of this dreadfully fatal disease. Dr. Osler says that "iron rarely acts well in this form of anemia," and we, I think, could tell him why this is so if he would be liberal enough to listen.

In arsenical poisonings it is not the red corpuscles alone which show the pathological changes. The white corpuscles also, come in for their share. The differential leucocyte count will show varying pathological changes, and the total leucocyte count is invariably increased. It may correspond to the leucocytosis of some septic condition or it may be tremendously increased as in leukemia.



Thus we see arsenic belongs to those very serious diseases of the blood, and those cases of anemia associated with serious organic disease, as gastric carcinoma for instance, before which the internist realizes his powerlessness to successfully meet the conditions, and it is in these extremes that arsenic sometimes gives us happy and unlooked-for service.

I believe we can only hope for some amelioration of these conditions from the use of arsenic in those cases which present more or less of the finer arsenic pathogenetic picture. One of the most valuable of these indications is the ever-increasing prostration, associated with the ever-increasing restlessness, mentally and physically; the cardiac weakness, and dyspnea, worse at and after midnight; the burning pains relieved by heat; the peculiar thirst, etc.

These are characteristic symptoms and tell us that arsenic bears a homœopathic relationship to the particular case, and consequently the patient will feel the effects of a dynamically acting drug. Arsenic under other conditions will do no good—regardless of dose.

One of the drugs that I always carefully differentiate from arsenic is acetic acid. Many others come to mind but space will not permit of their discussion.

#### AUTHORITIES QUOTED.

Dr. Robert Bartholow, (Drs. Cutler and Bradford).

Dr. William Osler.

Dr. John H. Clarke.

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THE OCCURRENCE OF MENSTRUATION AFTER CURETTEMENT.—The return of menstruation after curettement is a subject about which not much is mentioned in medical literature. Jaeger (Erlangen) has given some attention to the question and has found that curettement for endometritis or for diagnostic purposes does not affect the menstrual type in about 80 per cent., that is the period returns at the usual time. This fact seems to prove that menstruation is not dependent upon the structure of the mucous membrane but upon the activity of the ovaries. The return of the period is not so regular after curettement for abortion as when the operation is performed for endometritis. In most of the cases the menses return three or four weeks after operation. The duration and amount of flow and the stage of pregnancy within the first four months are without effect. The return of the period after abortion, just as after a regular delivery does not depend upon the regeneration of the uterine mucous membrane nor upon the involution of the uterus, but upon the antagonistic relations between the functions of the ovary and of the placenta.—*Zentralbl. f. Gyn.* 1911- 1338.

**REPORT, WITH FULL STATISTICS, OF THE WORK OF \*THE BOARD OF  
MEDICAL EXAMINERS REPRESENTING THE HOMŒOPATHIC  
MEDICAL SOCIETY OF PENNSYLVANIA, DURING ITS  
EIGHTEEN YEARS OF EXISTENCE,  
1894 TO 1912.**

PREPARED BY

JOSEPH C. GUERNSEY, A. M., M. D., SECRETARY.

IN the spring of 1893, the Legislature at Harrisburg passed a Medical Examiners' bill which provided for three separate boards of examiners, each board to consist of seven members, representing respectively the Homœopathic, Allopathic and Eclectic branches of the profession—thus doing equal justice to the three leading Schools of Medicine in Pennsylvania. On May 19, 1893, the Governor signed the bill and it thus became a law. This law went into effect in the spring of 1894, and continued operative until January 1, 1912. It was then succeeded by a new law creating the Bureau of Medical Education and Licensure, a board of seven members composed of Homœopathic, Allopathic and Eclectic physicians.

At the Annual Meeting of the Board of Medical Examiners, representing the Homœopathic Medical Society of Pennsylvania, held June 27, 1911, in his "Annual Report," Secretary Guernsey said:

"This is the last Annual Meeting our Board will ever hold. It has been in existence since April, 1894, a period of eighteen years; I have been a member of it for seventeen years and have the honor of being its secretary and treasurer for fourteen years. During my official incumbency I have endeavored to keep faithful, accurate and full minutes of all its proceedings; a reliable record of the examination markings of every candidate who has come before it; statistics of its work; the name and term of service of each of its members; a complete collection of all its examination questions."

At a special meeting of the Board of Homœopathic Medical Examiners of Pennsylvania, December 14, 1911, Secretary

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\* On January 1, 1912, this BOARD CEASED TO EXIST and was succeeded by the Bureau of Medical Education and Licensure.

Guernsey announced his intention of preparing full statistics and a history of this Board during its existence of eighteen years and of publishing the same in a Medical Journal. It was thereupon moved and carried that he be authorized to have reprints of the same made for distribution.

After careful consideration as to the most suitable and safest place of deposit for the preservation of its minute book and other records, the Board decided to place them at Harrisburg in the Department of Public Instruction, in a room set apart for medical archives, where they will be under proper care in a fireproof building and in steel cases.

The compiler of these statistics desires to state that when a candidate came before the Board the college of his graduation was not known to the examiners. After the examination had been held and the results ascertained and reported to the "Medical Council," the Secretary of said Council sent a list of the colleges (See Table B) to the Board of Examiners.



Members of the Board of Medical Examiners, Homœopathic Medical Society of Pennsylvania.	Date of Service.	Length of Service.
Joseph C. Guernsey, M. D., Philadelphia.	February 6, 1895—December 31, 1911.	16 years, 11 months. Board ceased to exist.
Edward Cranch, M. D., Erie.	January 17, 1894—March 1, 1908.	14 " 2 " Term expired.
Gustave A. Mueller, M. D., Pittsburgh.	October 2, 1899—December 31, 1911.	12 " 3 " Board ceased to exist.
Caleb S. Middleton, M. D., Philadelphia.	January 17, 1894—February 6, 1895.	12 " Resigned.
	December 9, 1899—December 1, 1910.	
John J. Detwiller, M. D., Easton.	February 6, 1895—March 1, 1906.	11 " 3 weeks. Term expired.
Augustus Korndoerfer, M. D., Philadelphia.	January 17, 1894—September 21, 1903.	9 " 8 months. Resigned.
Lewis H. Willard, M. D., Allegheny.	October 21, 1897—July 30, 1906.	8 " 9 " Died.
Daniel P. Maddux, M. D., Chester.	October 21, 1903—December 31, 1911.	8 " 2 " Board ceased to exist.
Isaac G. Smedley, M. D., Philadelphia.	January 17, 1894—December 1, 1899.	6 " Died.
Harry M. Bunting, M. D., Norristown.	March 1, 1906—December 31, 1911.	5 " 10 " Board ceased to exist.
John F. Cooper, M. D., Allegheny.	January 17, 1894—August 19, 1899.	5 " 7 " Died.
Christian P. Seip, M. D., Pittsburgh.	November 15, 1906—December 31, 1911.	5 " 6 weeks. Board ceased to exist.
William Alvah Stewart, M. D., Pittsburgh.	January 31, 1908—December 31, 1911.	3 " 11 months. Board ceased to exist.
Hugh Pitcairn, M. D., Harrisburg.	January, 1894—August 19, 1897.	3 " 7 " Resigned.
Louis Plumer Posey, M. D., Philadelphia.	December 9, 1910—December 31, 1911.	1 " 3 weeks. Board ceased to exist.
C. F. Bingham, M. D., Pittsburgh.	January 17, 1894—February 6, 1895.	1 " 3 " "

*OFFICERS OF THE BOARD.	Date of Service.	Length of Service.
President:—		
Augustus Korndoerfer, M. D.	{ April 3, 1894—April 7, 1896.	6 years 3 months.
Hugh Pitcairn, M. D.,	{ April 5, 1898—June 25, 1902.	"
Edward Cranch, M. D.,	April 7, 1896—April 6, 1897.	1 "
Lewis H. Willard, M. D.	April 6, 1897—April 5, 1898.	1 "
Gustave A. Mueller, M. D.	June 25, 1902—June 26, 1906.	4 "
C. S. Middleton, M. D.	June 26, 1906—June 26, 1907.	1 "
Daniel P. Maddux, M. D.	June 26, 1907—June 21, 1910.	3 "
	June 21, 1910—December 31, 1911.	1 " 6 "
Secretary-Treasurer:—		
Isaac G. Smedley, M. D.	April 3, 1894—April 7, 1896.	2 "
Joseph C. Guernsey, M. D.	{ April 7, 1896—June 30, 1905.	"
C. S. Middleton, M. D.	{ June 26, 1907—December 31, 1911.	14 "
	June 30, 1905—June 26, 1907.	2 "
Delegates to the National Confederation of State Medical Examining and Licensing Boards:		
Augustus Korndoerfer, M. D.	1894—1904.	11 "
Edward Cranch, M. D.	1905—1907.	3 "
Joseph C. Guernsey, M. D.	1908—1912.	5 "
Offices held in the National Confederation of State Medical Ex- amining and Licensing Boards:—		
Augustus Korndoerfer, M. D., Member of Executive Council.	Elected 1894—1904.	"
Daniel P. Maddux, M. D.	" 1900—1911.	"
Joseph C. Guernsey, M. D.	Ex-Officio 1908—1911.	"
	Elected 1911—1912.	5 "
Joseph C. Guernsey, M. D., Second Vice-President.	" 1908—1909.	1 "
Joseph C. Guernsey, M. D., First Vice-President	" 1909—1910.	1 "
Joseph C. Guernsey, M. D., President.	" 1910—1911.	1 "

\*Organization of the Board, April 2, 1894. President pro tem, John F. Cooper, M. D.; Secretary pro tem, Edward Cranch, M. D.

TABLE A.

Table A shows the number of "applicants" at each examination held by this Board from June, 1894, to December, 1911, inclusive; the general average of those examined (which includes successes and failures); and the rank of each examination. Thirty-seven examinations were held; the highest general average of any class examined was 89.67 obtained in June, 1906; the lowest general average of any class examined was 69.96, obtained in December, 1909.

Date.	Number Examined.	General Average.	Rank.
June, 1894	43	77.02	32
October, 1894	5	78.98	29
February, 1895	8	82.49	21
June, 1895	38	82.44	22
December, 1895	13	85.92	9
June, 1896	64	82.37	24
December, 1896	8	84.07	15
June, 1897	57	86.13	8
December 1897	9	71.33	36
June, 1898	57	*76.87	33
December, 1898	20	82.60	20
June, 1899	51	79.99	26
December, 1899	11	82.39	23
June, 1900	30	82.64	19
December, 1900	10	77.42	30
June, 1901	38	87.45	4
December, 1901	9	77.32	31
June, 1902	52	86.32	7
December, 1902	6	79.02	28
June, 1903	60	84.02	16
December, 1903	12	83.68	17
June, 1904	54	87.44	5
December, 1904	8	73.00	35
June, 1905	36	89.62	2
December, 1905	10	83.18	18
June, 1906	39	89.67	1
December, 1906	7	88.04	3
June, 1907	47	87.10	6
December, 1907	6	84.98	13
June, 1908	28	85.77	11
December, 1908	4	80.79	25
June, 1909	44	85.38	12
December, 1909	4	69.96	37
June, 1910	34	79.32	27
December, 1910	5	75.60	34
June, 1911	39	84.18	14
December, 1911	5	85.80	10
	<hr/> 971	<hr/> 83.43	

Total number examinations, 37. \*Number failed, 22.



TABLE B.

Table B shows all the Medical Colleges from which the applicants came; the number of applicants from each college; the number passed and failed, also the percentage passed and failed, from each college; finally, the number of applicants, and their colleges, who withdrew from an examination prior to its completion. The Hahnemann Medical College of Philadelphia makes a notable showing. Out of 735 examined, a percentage of 92.51 passed, and 7.49 failed; in other words, about 92 applicants out of every 100 passed successfully.

Colleges.	June, 1904—December, 1911, Inclusive.					
	Number Exam.	Number Passed.	Number Failed.	Per-centage Passed.	Per-centage Failed.	Number With-drew.
1.—Atlantic Medical College .....	4	3	1	75.00	25.00	
2.—Boston University School of Medicine .....	16	14	2	87.50	12.50	
3.—Chicago Homœopathic Medical College .....	14	12	2	85.72	14.28	
4.—Cleveland Homœopathic Hospital College .....	1	1	0	100.00	00.00	2
5.—Cleveland Homœopathic Medical College .....	100	73	27	73.00	27.00	
6.—Cleveland Homœopathic Medical College and Worcester University .....	1	1	0	100.00	00.00	
7.—Cleveland Pulte .....	7	6	1	85.71	14.28	
8.—Cleveland <sup>1</sup> University of Medicine and Surgery .....	24	12	12	50.00	50.00	
9.—College Physicians and Surgeons, Columbia University .....	1	1	0	100.00	00.00	
10.—Dunham Medical College and Hospital, Chicago .....	4	3	1	75.00	25.00	
11.—Hahnemann Hospital College, San Francisco .....	1	0	1	00.00	100.00	1
12.—Hahnemann Medical College and Hospital, Chicago .....	13	9	4	69.23	30.77	
13.—Hahnemann Medical College, Philadelphia .....	735	680	55	92.51	7.49	3
14.—Hering Medical College, Chicago .....	3	3	0	100.00	00.00	
15.—Homœopathic Medical College, University of Michigan, Ann Arbor .....	1	1	0	100.00	00.00	
16.—Jefferson Medical College .....	1	1	0	100.00	00.00	
17.—Maryland Medical College .....	1	1	0	100.00	00.00	
18.—New York Homœopathic Medical College .....	10	10	0	100.00	00.00	
19.—New York Medical College and Hospital for Women .....	3	3	0	100.00	00.00	
20.—Pulte Medical College, Cincinnati .....	8	7	1	87.50	12.50	
21.—Southern Homœopathic Medical College, Baltimore .....	13	8	5	61.54	38.46	
22.—Southwestern Homœopathic Medical College, Louisville .....	1	1	0	100.00	00.00	
23.—Trinity University, Toronto .....	1	1	0	100.00	00.00	
24.—University of Michigan .....	4	4	0	100.00	00.00	
25.—University of Pennsylvania .....	1	1	0	100.00	00.00	
26.—Western Homœopathic College, Cleveland .....	1	1	0	100.00	00.00	
27.—Western Pennsylvania Medical College .....	1	1	0	100.00	00.00	
28.—Women's Medical College of Pennsylvania .....	1	1	0	100.00	00.00	
	971	859	112	88.47	11.53	6

TABLE C.

Table C shows the very highest averages, to wit, all those above 95; name of recipient and college of graduation:

Date.	Name.	Gen. Aver.	College.
February, 1895	G. A. VanLennep, M. D.,	96.71	Hahnemann, Philadelphia.
June, 1895	R. J. Abele, M. D.	98.86	Hahnemann, Philadelphia.
December, 1895	A. Cookman, M. D.,	99.71	Hahnemann, Philadelphia.
June, 1896	A. Korndoerfer, Jr., M. D.,	98.71	Hahnemann, Philadelphia.
December, 1896	Anna D. Varner, M. D.,	96.57	Cleveland Homeopathic Medical College.
June, 1897	John E. Dehoff, M. D.,	97.28	Southern, Baltimore.
June, 1898	Oscar E. Boericke, M. D.,	95.43	Hahnemann, Philadelphia.
December, 1899	R. H. Woodruff, M. D.,	96.00	Hahnemann, Philadelphia.
June, 1901	Roy C. Cooper, M. D.,	96.43	Boston University School of Medicine
June, 1902	John E. James, Jr., M. D.,	98.28	Hahnemann, Philadelphia.
June, 1904	William Scott Piper, M. D.,	95.14	Hahnemann, Philadelphia.
June, 1904	Alfred Woodhouse, M. D.,	95.71	Hahnemann, Philadelphia.
June, 1905	Ernest A. Farrington, M. D.,	99.28	Dunham Medical College.
December, 1905	Frank Milton Hamblin, M. D.,	95.43	New York Homeopathic Medical College.
June, 1906	Joseph Valentine Francis Clay, M. D.	96.43	Hahnemann, Philadelphia.
June, 1906	Arthur Girard Cranch, M. D.,	97.14	New York Homeopathic Medical College.
June, 1906	Frederic Simon Morris, M. D.,	98.14	Hahnemann, Philadelphia.
June, 1906	Pius Albertus Noll, M. D.,	95.14	Hahnemann, Philadelphia.
June, 1906	Jesse Howard Swick, M. D.,	95.00	Hahnemann, Philadelphia.
June, 1906	Charles Hill Tait, M. D.,	96.72	Hahnemann, Philadelphia.
June, 1907	Roscoe Livingston Perkins, M. D.,	95.72	Hahnemann, Philadelphia.
June, 1909	Royal August Koronski, M. D.,	95.14	Hahnemann, Philadelphia.
June, 1911	Rodman Ellison Sheen, M. D.,	98.14	Hahnemann, Philadelphia.

TABLE D.

Table D shows the very lowest personal averages, to wit, those below 50; also the colleges of graduation:

Date.	General Average.	College.
October, 1894	45.43	Cleveland University of Medicine and Surgery.
December, 1895	49.00	Cleveland University of Medicine and Surgery.
December, 1895	40.43	Hahnemann, Philadelphia.
June, 1896	48.28	Hahnemann, Philadelphia.
December, 1897	47.71	Cleveland Homœopathic Medical College.
June, 1898	41.28	Hahnemann, Philadelphia.
June, 1899	47.71	Cleveland Homœopathic Medical College.
June, 1899	46.00	Southern, Baltimore.
June, 1900	43.29	Hahnemann, Philadelphia.
June, 1903	49.14	Cleveland Homœopathic Medical College.
December, 1904	49.86	Cleveland Homœopathic Medical College.

As seen in above Table, no Applicant received an Average below 50 after 1904. This shows marked improvement in Medical Education.

TABLE E.

Table E presents a general summary of all the results, June 1894 to December, 1911, inclusive:

Total number of examinations in 18 years .....	37
Total number of applicants examined in 18 years .....	971
Total number of applicants passed in 18 years .....	859
Total number of applicants failed in 18 years .....	112
	— 971
Percentage of applicants passed .....	88.47
Percentage of applicants failed .....	11.53
General average of all applicants examined in 18 years .....	83.43
General average of all applicants passed .....	85.86
General average of all applicants failed .....	64.83
Total number examined in 18 years: Men, 927; women, 44.	
Total number failed once .....	58
Total number failed twice .....	14
Total number failed three times .....	6
Total number failed four times .....	2
Highest personal general average, man .....	99.71
Highest personal general average, woman .....	96.57
General average attained by 927 men, 18 years .....	83.67
General average attained by 44 women, 18 years .....	78.43



**ELECTROTYPED HOMŒOPATHY.**

BY

CHAS. H. HUBBARD, M. D., CHESTER, PA.

(Read before the Homœopathic Medical Society of the State of New Jersey.)

THE designation, electrotyped homœopathy, is not employed as a term of reproach or criticism, but as a convenient and suggestive expression to introduce certain potential factors connected with the practice of homœopathic medicine.

Although it is universally admitted that the practice of medicine is not an exact science, it is the writer's belief that such is the case wholly and only because finite man is not a perfect being. The Architect of the universe, when He created this world and all that is in it, did, among the infinite perfections of His divine will, make absolute provision for healing the sick. But, because of man's limitations he is unable to accurately interpret or apply the provisions made by the Almighty.

It is an old and familiar axiom, that if you would know a thing, go to work at it. As a general proposition this principle is an accepted truism. Hence, one may be warranted in saying, to know homœopathy, practice it, work at it. And yet, would it not be presumptuous to assume to practice homœopathy without at least a rudimentary knowledge of the Homœopathic *Materia Medica*. Observation warrants one in the conclusion that it is possible to have a fair knowledge of our *Materia Medica* and know little of the law of cure upon which homœopathic philosophy is founded. And conversely, one's knowledge of the system of cure by the law of *similia*, may be faultless, and yet have a very superficial knowledge of *Materia Medica*. Wherever these vital factors are wanting in a subject, a shining exponent of homœopathy is hardly to be expected. Hence, it is logical to conclude that while these cognate subjects, Homœopathic Philosophy and *Materia Medica*, may be studied separately, they cannot be safely divorced in actual practice but must be "worked" co-ordinately in order to realize the highest conception of homœopathic practice. And ideals are said to be the world's masters. It is assumed that one may practice homœopathy and not believe in the law of *similia*. Further, that one may fully believe in homœopathic philosophy and not

practice it. And again, one posing as an homœopathist may become so muddled and disorganized in faith and practice, that he does not know what he believes and hence, by no torture of the imagination could such an one define what system of practice he employed. In fact, it is pertinent to inquire, Who could escape the above appellation of electrotyped homœopathist, if immunity depends upon a strict Hahnemannian interpretation of homœopathy? And we must grant, that a certain degree of latitude should be permitted one in his conception and practice of homœopathic therapeutics.

The American Institute of Homœopathy, our court of last resort, has adopted the following definition: "A homœopathic physician is one who adds to his knowledge of medicine, a special knowledge of homœopathic therapeutics and observes the law of similia. All that pertains to the great field of medical learning is his, by tradition, by inheritance, by right."

In this definition, it appears to your essayist there is a decided incongruity—if not a positive contradiction: that one may practice any system or none at all; may use any kind of treatment ever employed in any age of the world and still be a homœopathic physician, providing he observes the "law of similia." How or by what magical system of reasoning or mysticism can one possibly avail himself of the numberless ways and things used from time immemorial, by every conceivable kind of human, from the pow-wow therapy of a naked Hottentot; the disgusting and horrible concoctions of men, most of them supposedly learned in medicine, on down through the ages to the present time when the healing art has reached the highest type of medical achievement known to the world, and at the same time observe the "law of similia"? It is manifestly impossible.

Disregarding the American Institute's definition, we find a great divergence of opinion among the doctors as to what constitutes homœopathic practice. That which one may consider perfectly legitimate as an avowed disciple of homœopathy, may be condemned and stigmatized as rank apostasy by another.

The "holier than thou" apostle of homœopathic philosophy may be as far removed from the real intent and practice of Samuel Hahnemann and his true followers, and as much of a therapeutic heretic, and a menace to the cause of homœopathy, as the one who is bound by no law or system but practices medicine as he pleases.

Undoubtedly, the truth lies somewhere between these divergent and widely separated forms of practice.

In any event the practitioner must be accorded the right to practice as he will. Nevertheless, we believe that the great desire and purpose uppermost in the heart of every physician is to do the best he can for every ailing creature coming under his care.

Furthermore, it is our firm conviction that very few homœopathic physicians employ drugs and methods other than homœopathic because of a disbelief in the law of similia; but rather, because of a need of the necessary knowledge of the homœopathic *Materia Medica* to warrant them in prescribing in accordance with the law of similars. When they think of a remedy that seems to them to be homœopathic to the case, it is employed and their success with it joyfully proclaimed. Others fail to prescribe according to the totality of the symptoms, because of early association with pseudo-homœopathy, electrotyped homœopathy. And still others fail because their preceptor or family physician made little or no pretense of selecting remedies homœopathically.

Occasionally one will openly slur their own school of medicine—even as a dirty bird fouls its own nest.

It is fair to assume that not a few enter the medical college with little or no conception of homœopathic philosophy and apparently with no desire to have any. And altogether too many leave college with no well grounded knowledge or belief in the fundamentals of homœopathic philosophy. Such are electrotyped homœopathists of the most reprehensible character.

For this deplorable condition there is undoubtedly a divided responsibility. "When the fathers eat sour grapes the children's teeth are set on edge."

Apparently there are uncounted numbers who never read Hahnemann's *Organon*, and know little or nothing regarding the very foundation of our faith. To profess to be a homœopathic physician and at the same time wink at the most flagrant violations of its cardinal principles, is a stigma difficult to render surgically clean by any process known to man.

To resort to anodynes, hypnotics, etc., for every severe or protracted pain; to rush into operative procedures without giving a thought to drug therapy, is no more censurable or non-homœopathic than it is to persist with the "indicated remedy"



in a case of acute iritis when a mydriatic is demanded, or to withhold and denounce the use of antiseptics in an offensive suppurating ear.

With man's antecedents, environment, teaching, etc., so widely separated and diversified, no uniform nor constant agreement in any of the activities of life can be expected to exist. However, it is said that "consistency is a jewel," and it is well to remember the eternal fitness of things.

When intelligent patients claim that they cannot distinguish between homœopathic and allopathic treatment—if the appearance, taste, etc., of the drugs used, together with the various accessories, is any criterion for judgment—it is safe to conclude some one has not rendered unto Cæsar the things that are Cæsar's.

To really practice homœopathy and not play at it, is no holiday affair. Laziness promotes electrotyped homœopathy, and tends to the development of professional sterility, and should have no place in the curriculum of the new school physician.

While a few mortals seem to absorb *Materia Medica* as easily as a sponge absorbs water, the great rank and file approach its study with fear and trembling, and never feel wholly satisfied with their knowledge of it. But with unbounded faith and studious, determined application, any ordinary mind may be sufficiently equipped to fight disease more successfully with the homœopathic remedy than can the brightest mind with all the other methods combined.

The honored and lamented Dr. E. A. Farrington, often declared that it was his belief that whenever a cure follows the administration of a medicine, no matter how large the dose or how many things are combined, the cure resulted because somewhere in the prescription there existed an element or force that was homœopathic to the case.

Nature, given half a chance, will force her way. Nature's laws are so perfectly adjusted that they work together in absolute unity and harmony, but when nature is perverted there is discord and conflict. And while the law of *similia* works within the orbit of its own limitations the same as any other natural law, faith, honesty and intelligence should aid and protect the normal expression of that law, so that the dignity of the homœopathic profession and its shibboleth, *Similia Similibus Curantur*, may ever stand before the world in all its proud prestige and supremacy, a law, immutable and unchangeable.

## ECZEMA—A SYNOPSIS, FOR THE GENERAL PRACTICIAN.

BY

PERCY H. EALER, M. D., PHILADELPHIA.

(Read before the Oxford Medical Club, March, 1912.)

ECZEMA should be the best known, and the most accurately diagnosed of any of the so-called diseases of the skin. In frequency it ranks all of the skin manifestations, forming, as it does, about 30 per cent. of cases. Its relative importance is, therefore, self-evident. But for all this, we often fail to recognize it, or, on the other hand, mistake something else for an eczema. Stelwagon attributes much of our difficulty in diagnosing, to our proneness to guess something rare, instead of keeping in mind the more common conditions which would, of course, increase the chances of our guess.

Eczema is a dermatitis, that is, an inflammatory condition of the skin, with certain peculiar or essential characteristics; these include redness, particularly thickening and infiltration, more or less oozing of a serous character and accompanied by itching, often severe, also burning. Stelwagon, in summing up his definition, describes it as a catarrhal inflammation of the skin. The Greek origin of the word eczema signifies to boil over. The textbooks teach that eczema is both acute and chronic. The term acute is confusing, and we think should apply more especially to the severity of an attack than its course, as an acute or rapid course in eczema is rare.

Beginning insidiously, attacking usually small areas, spreading gradually; the course is one of slow progress, hence, sluggish or chronic. It is customary to describe for clinical convenience four phases of eczema. The erythematous, vesicular, papular and pustular forms, but they are all expressions of one and the same morbid process; the lines of demarcation between the different varieties are not always sharply drawn. Very often there is a mixture of them, and the name applied is because that particular lesion is most in evidence.

*Erythematous Eczema* is the form in which redness predominates, and with the redness more or less of that thickening and infiltration that helps to distinguish an eczema from other forms of dermatitis. This variety is more frequently seen in adults of middle or later life, appearing especially on the face,

arms, or about the genitals. Beginning as spots or small areas, which gradually coalesce, until at times large ones are involved. Recurrences are frequent. If the course be somewhat rapid or mild, it will end with a small amount of desquamation; but more often it runs into the chronic stage, ending in one of the so-called secondary forms, probably more frequently eczema squamosum.

*Vesicular Eczema.* Perhaps one of the most common types is that phase of the trouble, in which if you see the patient early, in addition to the redness you will observe many pin points or small vesicles, more often, however, the vesicles will have been ruptured by rubbing and scratching, leaving small glistening points from which will be seen the oozing serum, which drying, later forms crusts. These vesicles are formed by the bulging upward of one or more layers of the epithelium. Perhaps the most common examples of this variety of eczema is that seen on the faces of infants. The so-called milk crusts of the older writers.

*Papular Eczema* is characterized by the appearance upon the skin's surface of small, solid, red elevations, caused by the projecting upward of the papillæ. This eruption is usually at first discrete or in small patches. Later coalescing it forms at times large areas, when the papules lose their distinctness, but the furrows of the skin become very pronounced. The itching in papular eczema is usually very severe, owing to the irritation and pressure of the nerve termini in the papillæ; with the itching there follows, of course, more scratching, excoriation, and liability to secondary infection. Perhaps the more common seats of this variety are the arms, back and legs. It is resistant to treatment, and is prone to recur.

*Pustular Eczema* is also regarded as a primary type, but is really more often a secondary form. When primary it usually appears about the head and face of poorly nourished children, or the so-called scrofulous. The pustulation, however, is often engrafted upon the vesicular and papular forms, owing to the infection following the scratching, and giving rise to a condition known as staphylococcia, called so from the organism more often producing it.

*Eczema Rubrum et Squamosum* are the two principal secondary, or modified, manifestations of eczema; that is, later stages of the disease; they are never the early forms. That known as rubrum usually succeeds the vesicular variety. After



the breaking or rupturing of the vesicles, there is left a denuded raw, red surface, hence the name. This is often seen on the faces of infants, the long, lasting cases of the so-called milk crust condition. The squamous variety more often follows the erythematous and papular forms, here with less oozing but more dryness, the long lasting inflammation results in pronounced scaling. This condition is perhaps oftener seen upon the hands and legs of adults in middle or later life.

*Etiology.* The study of the etiology of eczema, as yet leaves much to be desired. Schamberg well says that it is almost incredible that so constant a condition should have so protean an origin. Some cases are traceable to internal causes, others are of undoubted external causation. Of the former the various toxæmias, such as cholæmia, uræmia, indicanuria are regarded as blamable. While in those of external origin parasites probably stand first. Traumatism, also the effects of heat or cold produce many cases. In some people there seems to be a something that renders them prone to attacks of eczema from causes that will not produce it in others.

*Diagnosis.* The diagnosis of eczema is a good deal like recognizing our fellow-man. We all have certain things in common, yet there are such differences, that an error, or a case of mistaken identity comparatively rarely occurs. So in the recognition of eczema, it is an inflammation of the skin, but peculiar in kind. An attack does not usually involve large areas at first. It begins rather insidiously, and with, or following the redness there is that thickening and infiltration to which we have called attention. You can observe this most satisfactorily, by drawing your finger or fingers over the inflamed areas, beginning outside the involved space and bringing the fingers toward it. You can hardly fail to detect it. Soon or simultaneously will be seen numbers of fine vesicles or papules and these always accompanied by itching or itching and burning. At first these vesicles or papules may be discrete, but soon coalesce and the involved patch spreads out in different directions, but with this distinction, that as the patch develops it does not heal in the center as do many other conditions. Eczematous areas usually have not sharply defined borders or edges—they tend to fade out gradually into the normal skin. Of course, as a rule, when an eczematous patient comes to us, the attack is fully developed, but a careful scrutiny will help us determine its lesional type and course. To aid in doing this al-

ways insist on the patient showing all the eruption wherever it may be.

*Differential Diagnosis* to be completely described in so big a subject, with all its possibilities of association with anything or everything in skin troubles would require a large sized volume. Recollect, please, that this effort is but an attempted synopsis, and don't be scared. However, there are a few points on which our memories should be refreshed.

First. The condition referred to as staphylococcia. This follows in the train of the scratching and infection therefrom, resulting in more or less thick scaling and crusting, with pustulation. This is often mistaken for impetigo contagiosa. True impetigo is not seen so frequently and is much more resistant to treatment. Those cases of impetigo cured in two or three days were more than likely not genuine. In appearance the impetiginous lesions are usually discrete. They are superficial ones and do not involve the deep layer of the skin. The crusts are thinner, loose around the edges, and look, as Fox says, as if the little masses were "stuck on" the skin.

*Psoriasis* may at times be mistaken for eczema, but usually the differences are clearly defined. Psoriasis appears most often on extensor surfaces, elbows, knees, etc. Eczema more often on the flexor surfaces. The psoriatic lesion is usually sharply outlined, with profusion of the white pearly scales on top. Eczematous lesions are not so clearly outlined, fading away gradually into the normal skin, with less scaling, and have not the marked white or pearly color of psoriasis.

*Scabies* at times causes one to think of eczema, but the history often helps to differentiate them. Scabies is highly contagious. Eczema is non-contagious. Scabies nearly always begins on the hands, and more especially in the webs between the fingers, and is distributed by the scratching over front of the body, in the axillæ, on the thighs, etc., with itching markedly worse at night. If the presence of the itch burrow can be shown, the diagnosis is settled. However, it should be borne in mind that an over-treated case of scabies, viz., one where treatment has been too prolonged, or traumatism from excessive scratching can produce a superadded eczema.

*Seborrheic Dermatitis*. This disease of the skin was formerly included as an eczema, and some still call it seborrheic eczema. It is the one that most of us are likely to fall down upon in differentiating, although it is not a true eczema. There is

not the oozing or thickening of the skin, the scaliness is more greasy in character, the disease often begins in the scalp, extending downwards, and the involved areas are sharply outlined with distinct borders. It is probably of parasitic origin, it being not very unusual to have two or more of a family afflicted at the same time. There is also a predilection for certain areas, particularly the sternal region and in the axillæ.

*Treatment.* Well may we all exclaim, "Ah, there's the rub"—yet eczema is not by any means an incurable disease. On the other hand, the great majority of cases are cured. It is true that there is no specific for it, and no one plan of procedure is applicable to all cases, for the very simple reason that the origin or cause is so variable, therefore, no matter how trite, first of all, if possible, ascertain the cause and bring about its elimination. When of internal origin look after the toxæmias, particularly the intestinal; also those from the renal tract. Correction of diet is of great importance, but often is a question of quantity rather than kind. In general, minimize the foods tending to produce an excess of indican, or excess of uric acid. If gout or diabetes is present, either can very readily account for the eczema.

*Constipation.* Some writers lay considerable stress upon constipation as a factor in eczema. In its correction we have had much better results from having patients take one or two glasses of water *with* their meals. Water between meals is thrown out by the kidneys with little or no effect upon the constipation.

*Local Treatment* is, in the opinion of most teachers, the more important in a majority of instances. A point not to be overlooked is—do not have the medicaments too strong; it is far better to err on the other side, especially in the earlier stages; soothing treatment is what is required.

*Water* locally is nearly always harmful to these cases. Occasionally an exception has to be made; then modify it by the addition of starch, bran, or borax. The French dermatologists use starch water considerably. *Removal of Crusts* is often necessary before actual treatment can be begun. This must be done by softening, probably the best of all for this is olive oil. Linseed oil can also be used; at times when crusts are very adherent, it may be necessary to remove them by poulticing

*Lotions, Ointments, Etc.* In many instances soothing oint-



ments are useful in the acute or early stages, but in some cases no salve at all can be borne; here much more relief is afforded by lotions. In many cases also an excellent plan is to use the lotion during the day with an application of ointment at night.

The following are a few formulæ, devised or modified by Dr. Schamberg, and of their value I can bear testimony:

℞ Resoraini  
 Ac. Borici aa ʒi  
 Glycerini fʒi  
 Zinci Oxidi ʒii  
 Aquæ q. s. fʒvi  
 or Aquæ  
 Aquæ Calcis aa ʒiii.  
 M.

Useful in moist eczema, and especially in conjunction with following ointment:

℞ Ac. Phenisi grs. x  
 Hydrar Chlor. Mit. grs. xv  
 Zinci Oxidi  
 Pulvis Amyli aa ʒi  
 Petrolati ʒiv  
 M. ft. Ungt.

A simple but decidedly useful lotion is saturated solution boric acid, applied frequently on a compress. Think of it in actively inflamed conditions.

Another excellent formula is:

℞ Ac. Phenici ʒi  
 Zinci Oxidi ʒiii  
 Pulvis Calaminæ ʒi  
 Aquæ Calcis q. s. fʒvi

In *Chronic Eczema* that has baffled treatment and where there is marked thickening—a useful salve is:

℞ Picis Liquidæ, or Olei Cadini ʒi-ii  
 Zinci Oxidi ʒi  
 Vasalini ʒi

Tar, however, should not be used in acute conditions; it is too stimulative.

*Eczema Capitis*, especially with pustules.

℞ Sulph. Præcip grs. xxx  
or Hydrar. Ammonæ grs. xxv  
Vasalini ʒi

*Eczema Faciei*, with much crusting. At times an oil lotion is the more helpful, combining both salve and lotion:

℞ Resorcini  
Ac. Borici aa ʒi  
Olei Amygdala Dulcis fʒii  
Aquae Calcis fʒiv  
Zinci Oxidi ʒii

Shake well.

X-ray treatment is particularly valuable in the recurrent vesicular type of eczema, but this is the case we must refer to the expert specialist.

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#### SALVARSAN AND THE EYE. REPORT FROM THE GERMAN LITERATURE FOR THE PAST YEAR.

BY

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IN the February number of the *Klinische Monatsblätter für Augenheilkunde* is an article written by Dr. E. Wiegman, entitled "Zur Salvarsantherapie bei Augenkrankheiten aufluetischer basis nobst Mitteilung einiger gunstig beeinflusster Falle von Augenmuskellahmungen." This article contains a complete review of the German literature of this past year on the relationship of the indications and contra-indications of salvarsan to ophthalmology. Appearing at this time in the history of salvarsan when its cures and its disagreeable complications are being considered by the medical profession, a translation of the above article seems not to be without value.

Most all ophthalmologists agree in the failure of salvarsan in keratitis parenchymatosa e lue congenita. Uhthoff reported eighteen cases treated with "606," only three cases had a direct influence; nine cases had no indication of improvement, and two cases in spite of salvarsan became decidedly worse. Benda,

among twelve cases, saw no result. Manzutto in four cases could not see the slightest improvement. Wesseley saw no results among six cases. In his article he collected seventy cases of keratitis parenchymotosa out of the entire German literature, whose course differed in nowise from the classical treatment hitherto prescribed. In the Japanese eye clinic of the University of Tokio, salvarsan was used on all cases of keratitis parenchymotosa and was found insufficient. To these statistics I may add that at the May meeting of the Wills's Eye Hospital staff, Dr. Wm. Campbell Posey reported five cases of parenchymotosa keratitis treated with salvarsan, without any result, and furthermore announced his intention of discontinuing its use for this disease.

Opposed to the above views is Seidel, of the University of Heidelberg eye clinic. He reports exceptionally prompt action in ten severe cases of keratitis parenchymotosa. Peppermüller, Hoffman, and De Lapersonne and Michel report favorable cases in their series. With acquired keratitis parenchymotosa Manzutto and Becker report very favorably for salvarsan.

Decidedly more encouraging are the experiences with diseases of the uveal tract of luetic origin treated with salvarsan. Manzutto reports very favorable results with salvarsan in iritis and iridocyclitis. Benda reports nine cases of iritis and iridocyclitis, with a rapid disappearance of the inflammatory symptoms. Uththoff reports four cases of iritis with great favor, but had two cases of choro-retinitis specifica without the slightest change. Becker saw very rapid recoveries in eight cases of luetic iritis, the vitreous opacities disappearing quite rapidly. Guglianetti observed a very good influence of salvarsan in a case of gumma of the ciliary body. Krückman found a very good influence of salvarsan in all his cases of specific uveal inflammation. De Lapersonne had three cases of iritis and iridocyclitis in young individuals with complete recovery in a few days. Gilbert reports a case of iritis with complete recovery in eight days. Elschmig reports much better success with salvarsan in all his cases of diseases of the uveal tract than with the classical treatment.

The results of this past year's experience with salvarsan at Hahnemann compels us to place ourselves on record as being most favorably impressed with salvarsan in fresh cases of luetic iritis. We have seen an acute case clear up in five or six days, also a large condylomata of the iris simply melt away in a



week's time after an injection of salvarsan. We have had an obstinate case of scleritis of specific origin clear up in two weeks after salvarsan injection, after being resistant to the mercurial treatment of over a month. This case I presented to the Clinico-Pathologic Society during the past winter. My clinical chief, Dr. Wm. Speakman, was amazed at the rapid recovery of two cases of iritis after salvarsan injection. Our experience with salvarsan in iridocyclitis at Hahnemann is very unfavorable. I had referred to me three cases of iridocyclitis which terminated in total blindness. In all these cases a terrific optic neuritis complicated the iridocyclitis with a total retinal detachment resulting. This terminal result has no relationship with the salvarsan, in spite of the fact the iridocyclitis followed the injection of "606." Clinically these cases presented manifestations which were characteristic of syphilis. In the above three cases blindness was very sudden, one case occurring during the night. I believe had these cases been in bed, with absolute rest, retinal detachment might have been avoided. What occurred, probably, was an acute lowering of the tension of the eye, acute hypotonia. This has been reported by Lauber even in cases of glaucoma. This is a rare condition and in order to avoid misinterpretation, I will say these three cases were referred to me from other clinics, and represent a few of many cases of iridocyclitis treated with salvarsan. One of these cases I presented to The Clinical Pathologic Society in May.

Taken collectively, reports of the treatment of syphilitic retinal and optic nerve affections with salvarsan, are less encouraging. Igersheimer praises salvarsan in these affections of the eye. He never saw an injurious effect in the visual apparatus. Peppermüller, Franke, Becker, report several cases of optic neuritis with complete recovery after one to three injections. Schieck reported a very beneficial effect of salvarsan in a case of optic neuritis with central scotoma. It may be well to report a case which was under the observation of the genito-urinary and eye clinic for four months. The patient contracted syphilis in the summer of 1911. In the latter part of August a terrific, persistent scleritis of the left eye appeared, which persisted until salvarsan was given. This was followed shortly by a typical syphilitic iritis for which a second injection was given. Complete rapid recovery followed. A few weeks later, patient came back complaining of a blurr over the left eye,

vision was counting fingers at one meter. The ophthalmoscope revealed a syphilitic neuritis. A third injection was given and the patient's vision returned to 15-70. This result was only temporary. The vision returned next week to counting fingers at one meter and remained so for a long time. The patient lost faith so the case could not be followed completely. Since these injections were given at a time when optic neuritis was considered a contra-indication for salvarsan, we were fearful of giving any more injections, but it would have been instructive to know what another injection would have done. De Lapersonne reported a similar case to the above. He obtained a very satisfactory result in a case of optic neuritis, which, after five weeks, showed inflammatory symptoms and loss of vision. Westhoff saw a case of optic neuritis showing beginning signs of improvement after salvarsan, which was followed by remissions and a retrobulbar neuritis in the well eye. Schanz reports a case of optic neuritis having gone through healing and remissions for two consecutive times with good terminal results with salvarsan injections; Uththoff saw no influence of salvarsan in three cases of tabetic atrophy. Manzutto reports unsatisfactory results of salvarsan in neuroretinitis and optic neuritis. Krückman reports that salvarsan has slight manifestations on the optic nerve in the form of a slight swelling and hyperæmia. This phenomenon I have shown to my colleagues several times in our eye dispensary. In one case, small hemorrhages from the larger veins around the optic nerve were present but no visual disturbances followed. Falta concludes that he will use "606" in optic neuritis or atrophy when mercury and potassium iodide have proven themselves ineffectual. Bahr believes salvarsan has more favorable chances in syphilitic optic neuritis when the Wassermann reaction is negative.

In regard to the effect of salvarsan on the paralysis of the ocular muscles of luetic origin, observations of the various ophthalmologists of the German clinics vary. Treupel saw a case of paralysis of the ocular muscles and choked disc clear up in a few days. Riche and Gelewski report favorably of salvarsan in cases of ophthalmoplegia. Uththoff reports a case of left internal ophthalmoplegia, in a man thirty-four years old, with complete recovery in three weeks. Agricola saw a case of paralysis of the third nerve in a tabetic patient recover in one-half year after salvarsan injection. Benda and De Laper-

sonne report favorable cases. Wiegman reports four cases of paralysis of the ocular muscles favorably influenced with salvarsan. Grunert saw some results with salvarsan in internal ophthalmoplegia in a series of nine cases. Two cases fully recovered. Becker observed a recovery from multiple paralysis of the ocular muscles due to cerebro meningitis, and also disappearance of the pupillary difference.

Of the lid affections, Schieck reports a favorable case of syphilitic tarsitis. Manzutto observed a rapid healing of a gumma of the lid.

Ehrlich explains the undesirable complications following the injection of salvarsan by the free toxins of the dead bacteria set free in some patients who possess an over-sensibility against toxins. Complications which appear shortly after the injection are explained by the fact that the death of a spirochæte produces localized swellings. If a swelling of this kind occurred in a bony canal compression of the nerve would result and functional disturbance would follow (optic neuritis, as an illustration). Later complications of salvarsan injection Ehrlich explains upon the theory that the deep-seated spirochætae, inaccessible to salvarsan, either escape its action or are partially destroyed, and suddenly multiplying give us severe complications. It is, therefore, not a bad effect of the arsenic. To support this is another fact that many such cases are controlled by repeating injections of salvarsan.

Schanz, Igersheimer, Pepper Müller, and Davis all report cases of optic neuritis following the injection of salvarsan, but were controlled by repeating injections. Macrocki saw a paralysis of the accommodation following the second injection of salvarsan. Finger, of Vienna, reports a case of optic neuritis and third nerve paralysis following salvarsan. Davids reports a re-occurrence of iritis, papulosa syphilitica after salvarsan injection which disappeared with the second injection. Igersheimer observed a neuro-retinitis appear five or six weeks after salvarsan injection, which disappeared with the second injection to be soon followed by hemorrhages into the vitreous, which again cleared up permanently with the third injection. Pepper Müller, Westhoff and Becker report similar cases. Plaut observed an optic neuritis developing one-half year after the injection, which ended in permanent blindness. Reisert observed a case of optic neuritis with vitreous hemorrhages appearing two months after the injection which resulted in total



loss of sight to the eye. Chronis records an optic neuritis developing six months after salvarsan injection. Pfalz saw a case of complete ophthalmoplegia develop three hours after salvarsan injection. Krückman reports a case of multiple hemorrhages in the vitreous following salvarsan.

The following deaths are recorded in the German literature: Almkvist reports a case of encephalitis hemorrhagica acuta three days after intravenous injection of 0.6 gm. Death followed six days after the injection.

Fisher records a similar case to the above. He administered salvarsan to a patient having an encephalitis hemorrhagica acuta. The patient reacted from the injection with chills and repeated spells of vomiting. The first injection was followed with an inunction cure of thirty inunctions, and forty days after the first injection the second injection of salvarsan was given—0.4 gm. Two and one-half days later the patient suddenly became unconscious, developed convulsive movements, cervical and spinal rigidity. Death followed within four days. Since this patient reacted to the mercury the author concludes that an exceptional sensitiveness existed in the patient against the metallic poisons whose effect was increased by the endotoxines of the spirochætæ. Hoffman injected a fifteen-year-old patient with an intravenous injection of 0.3 gm. salvarsan. Six days later he gave an intra-muscular injection. Five weeks later fever with gastric catarrhal symptoms and icterus appeared. For three days before patient's death, he was unconscious. Death followed exactly nine weeks after second injection. Post-mortem examination showed a subacute atrophy of the liver.

Kamnengieser reports a death after two intravenous injections. Three days after the second injection epileptiform convulsions, delirium and coma appeared. Death followed the next day. Post-mortem examination revealed brown atrophy, fatty degeneration of the heart muscle, fatty degeneration of the liver and kidneys, chronic leptomeningitis in the cerebellum and pons.

Mann records a case which developed unconsciousness, tonic and clonic convulsions with diminished reflexes three days after intravenous injection. Patient, however, recovered.

Gilbert published a case which developed an arsenical exanthemata and epileptiform attacks after 0.2 gm. salvarsan by intragluteal injection.

Westphal reports a death during the first night after an intra-gluteal injection.

Martin collected a series of deaths from the literature where salvarsan was given to patients who had cardiac and vascular diseases. He gives the following trio as contra-indications for salvarsan: Aortitis luetica, sclerosis of the coronary arteries and myocarditis.

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### ACUTE ANTERIOR POLIOMYELITIS. INFANTILE PARALYSIS.

BY

EDGAR CLEMENT, M. D., HADDONFIELD, N. J.

(Read before the New Jersey Homoeopathic Medical Society.)

PERHAPS no subject in medicine has been more discussed in the past year or two than this dread disease. While it is not a new disease, Dr. Lovett, in his report to the Massachusetts State Board of Health, says: "The medical profession of to-day is confronted with a task of constructing a new literature on the subject of infantile paralysis. What was written five years ago is to-day largely out of date, and the standard textbooks cannot naturally present the latest point of view so rapid has been the recent progress of our knowledge in regard to this disease."

Michael Underwood, an English physician in 1774, and again in 1789, described the disease as not having come under his notice in any medical writings, and his symptomatology covers many of the leading characteristics of the disease as we observe it to-day. Jacob Heine, of Stuttgart, in 1840, published the first accurate and complete description and established it as a recognized disease. It is increasing in frequency in all parts of the world. In the five years ending 1904, three hundred cases were reported. In the five years ending 1909, eight thousand cases were observed. Of those, five-sevenths occurred in the United States. Approximately 9,000 cases were reported in the United States in 1910 and less than 2,000 in 1911.

*Etiology.* Recent textbooks give under this heading: "Its true cause is unknown." This definition holds good to a certain extent to-day. But no disease has had more careful study and experimentation than this disease.

Wickman, of Berlin, in 1907, made careful studies of the Swedish epidemics, but failed to find the source of the contagion. Doctors Flexner and Lewis studied the two outbreaks of 1907 and 1909 in New York, but until September, 1909, they were unable to get the material they desired.

They obtained the spinal cords from two cases, one who died in five days after paralysis, which affected both legs. The lumbar cord was taken in a sterile condition twenty-six hours after death.

The second case, a child of nine years, died on the fourth day after the patient had been generally paralyzed, and the entire cord was procured twelve hours after death, and inoculated into animals four hours later.

The virus was injected into eighty-one monkeys. The incubation period, or time from the injection until paralysis averaged nearly ten days.

The shortest period being four days and the longest thirty-three. The monkeys remained normal until a period of about forty-eight hours before the onset of paralysis, then they began to be nervous and excitable, tired easily and a tremor of the head, face and limbs began to develop, following this the paralysis generally developed suddenly. Of the eighty-one, forty were paralyzed in the legs and twenty of these in both legs. Twenty-one were paralyzed in the arms. Ten in all four limbs.

Twenty-three of these monkeys died. Nine made actual recovery. It was estimated that fifty-four per cent. were fatal. Those that recovered were at the end of a month reinoculated, and in no instance was there a frank renewal of the disease. Two of them were sick for a few days, but recovered. It would, from this, be apparent that a child that has had the disease would be immune, and a preventive serum may be hoped for.

While Flexner and Lewis have not been able to isolate the organism, they have demonstrated the fact that the disease is an infectious one, and that the organism is still active after passing through Berkefeld filters, and that the naso-pharyngeal mucosa contains the virus and yields a filtrate capable of setting up the disease. They have also shown that one per cent. hydrogen-dioxid and 1 to 500 solution of permanganate of potash destroy the germ upon the mucous membrane. Two points of present practical value.



The Department of Health of Pennsylvania recently made a report on the examination of the blood in acute cases of poliomyelitis in human beings and in monkeys, in which they find an organism different in morphological characteristics from any hitherto described. In blood smears fixed in methyl alcohol and stained with carbol-thionia, the organism appears as a faintly stained blue rod with a regular cell wall about ten microns long and eight-tenths microne in width, curved at an angle of sixty to seventy-five degrees at one end, and at times both ends. Some have fine granular protoplasm and are free in the serum as well as in the body of the red blood cell. These were taken from ten cases in children, and thirteen in acute cases of monkeys. Blood smears were taken from three normal human beings and thirteen normal monkeys with negative results. This may open a new field for experiment.

Many theories have been advanced as to the method of transmission. The State of Massachusetts, in 1909, detailed three Harvard Medical School professors, with one recent graduate and a senior. These men studied and classified one hundred and fifty cases, the result of their observations is not only very interesting but very instructive. Former theories of the method of its spread are proven one by one to be wrong. In the one hundred and forty-two families containing the one hundred and fifty cases, one hundred and thirty-four had vermin, mostly flies, which were plentiful in one hundred and thirteen houses. Thirty-five of the cases had been in contact with other cases. Of the number, seven families had two cases, and one family had three. Sixteen per cent. recovered. The careful observation of these men show the fly to be the most frequent of any one factor and as this is a disease confined almost entirely to the fly season, I am more inclined to believe them to be the most common carrier of the disease, and Dr. Flexner has demonstrated that clean flies exposed to infected spinal cords, would subsequently produce the disease in monkeys.

*Pathology.* Doctors Robertson and Chesley, of Minneapolis, performed one hundred autopsies on cases of anterior poliomyelitis and make the following pathological conclusions:

"I. Acute anterior poliomyelitis is a specific infectious disease characterized pathologically by general toxemia affecting the paranchyma of the heart, liver and kidneys and the lymphoid tissues of the body, but spending itself locally on the structures of the spinal cord.

"2. Grossly the cord is congested and on transverse section shows softening and often hemorrhages in the gray matter of the two anterior horns.

"3. In the cord the infectious agent is located in the perivascular lymph channels of the anterior portions, especially invading the gray matter, but extending to the white matter and pia, and occasionally to the posterior horns. The brain stem and basal ganglion may be involved. In the cord the medulla and cervical and lumbar swellings are particularly affected.

"4. The characteristic lesion consists of collections of cells in the perivascular and pial lymph channels and tissue spaces of the anterior horns of these cells. The polymorphonuclear leucocytes appear early and are relatively few in number. They are soon displaced by endothelial cells arising from proliferation of the lining endothelium and lymphocytes coming from the blood and lymph streams.

"5. Edema of the interstitial tissue and degeneration and destruction of the ganglion cells are always present.

"6. The vessels are congested, their walls degenerated, and the capillary branches in the gray matter irregularly distended and often ruptured, giving hemorrhages, which always intensify markedly the amount of destruction. Thrombosis was not observed.

"7. Early degeneration of nerve fibres from the anterior roots is a constant feature.

"8. Stains for micro-organisms were uniformly negative."

#### SYMPTOMS.

Prodromal: Irritability, restlessness, pain in spine or extremities and apathy. The onset may be sudden, the child may be as well as ever when attacked, and there may be no prodromal symptoms.

#### *Important Symptoms During the Acute Stages:*

1. Fever, 100 to 106, duration from one to seven days.
2. Vomiting (present in 25 per cent. of New York cases).
3. Restlessness.
4. Apathy.
5. Rigidity of the neck.
6. Headache, frontal.
7. Delirium.
8. Stupor.

9. Convulsions.
10. Profuse sweating, early is a common symptom.
11. Constipation.
12. Photophobia.
13. Dysphagia.
14. Sluggish pupils.
15. General pain (early in 58 per cent.).
16. Absence of deep reflexes.
17. Cold extremities.

In about two or three weeks the spinal tenderness disappears and all symptoms but the paralysis have subsided. The paralysis will remain stationary a few weeks and improvement commences and continues in different muscles until absorption of the meningeal effusion has taken place. Then follows the permanent stage of atrophy of the muscles involved and contractions or bone deformities. Circulatory and nutritional changes render the parts involved cold and sweaty and generally cause a blueness. The electric reaction of the paralyzed muscles and nerves shows the reaction of degeneration. The anodal closure contraction being equal to or greater than the cathodal closure contraction. Deep reflexes are diminished or lost.

#### DIFFERENTIAL DIAGNOSIS.

*Cerebral Spastic Palsy* is marked by inco-ordinate muscular movement some times choreic. In infantile paralysis contraction is feeble or absent. In the former the limb is full sized and muscles are rigid; in the latter they are atrophied and flaccid. Reflexes are exaggerated in the former, feeble or lost in the latter. Intelligence is impaired in the former and normal in the latter disease.

*Cerebral Paralysis from Hemorrhage* caused by whooping cough or meningitis is usually hemiplegic and the face is often involved. The tendon reflexes are increased. Seldom is there muscular atrophy noticed, electrical reactions are normal.

In *Transverse Myelitis* and *Spastic Spinal Paraplegia* sensation and motion are both lost.

*Cerebrospinal Meningitis.* During the acute stage the symptoms of the two diseases as to convulsions, stupor, etc., may be quite similar, but there is no opisthotonos in anterior polio-



myelitis. Spinal puncture will show the bacillus. The paralysis is usually hemiplegic and will recover without atrophy.

*Neuritis.* The initial state is similar to poliomyelitis anterior, in the muscular tenderness and pain, but the sensitiveness is more persistent, and both motion and sensation are involved.

#### PROGNOSIS.

In Massachusetts in six hundred and twenty-eight cases the death rate was 8 per cent, and recoveries nearly 11 per cent. Of the one hundred and fifty studied cases referred to, there was an average of 16.7 per cent. which made complete recoveries. I have seen one case where both legs were completely paralyzed that made an entire recovery in nine weeks, and could walk without any apparent deformity. Another case I recall, in a child nearly two years old, in which both legs, one arm and the neck muscles were paralyzed, in five months was as well as ever apparently, with the exception of the left foot, which was slightly everted. The reaction of muscles to electrical excitation is an important element as regards both diagnosis and prognosis. Completely paralyzed muscles show diminished faradic irritability even after a few days, and at the end of two weeks response is permanently lost.

In muscles that continue to exhibit contractibility, gain may be expected and hope of improvement by massage, muscle training and electricity should not be given up as long as any voluntary or electrical contraction is present. A muscle that fails to respond to either faradic or galvanic stimulation at the end of six months is probably permanently disabled.

Lovett and Richardson's conclusions as to prognosis.

1. Complete or functional recovery in over 25 per cent. of patients examined at the end of four years.
2. Atrophy may exist without impairment of function.
3. In about half of the recovered patients the onset was mild.
4. The distribution of the paralysis in such cases was not essentially different from that of cases which do not recover.
5. The period of recovery in many instances occupied months, and in several cases from one to two years.

#### TREATMENT.

The early diagnosis of this disease is important, and some

advocate the examination of the cerebro-spinal fluid in every suspected case.

I do not think this advisable in every sudden high temperature one may run up against in children during the hot weather. Where there is much pain along the spinal column, it is good treatment to make a spinal puncture and remove the pressure and at the same time have the fluid examined for diagnostic purposes. Careful asepsis is essential. The patient must have the spine bent forward and the puncture made on a line drawn from the crests of the ilia, which will cross the fourth lumbar interspace. The needle should be especially sharp and should not be inserted beyond the subarachnoid space. In children the depth is from 2 to 4 cm. From 5 to 30 cc. may be drawn. More of the fluid is in great excess. The cerebro-spinal fluid at the height of the lesions in the meninges exhibits a very slight turbidity or opalescence, best seen on gently agitating the fluid and due to a large increase in white corpuscles. It contains an excess of protein matter. The white corpuscles consist partly of polymorphonuclear and partly mononuclear (lymphatic) cells. The excess of protein is readily detected by the Noguchi's butyric acid test. Bacteria are absent. In rare instances it becomes necessary to exclude tuberculous meningitis, by examining for tubercle bacilli.

The use of urotropin (hexamethylenamin) seems to be the most rational treatment in the early stages. Doctors Flexner and Clark have experimented with this drug upon monkeys. The drug is well borne by them and very soon after the administration of large doses by the mouth, its presence can be demonstrated in the cerebro-spinal fluid. The dosage is two grains every two hours during the acute state, or during the first two or three days.

It is very important to keep up the elimination through the bowels and kidneys. Constipation is the rule, and enemas of water or oil should be used daily. Plenty of water, milk, butter milk, broths or grape juice should be given.

There is a difference of opinion as to just when to begin to do something for your patient. I spent a day in Boston with specialists, who were united in the opinion that from two to four weeks, while the spinal irritation continued there must be absolutely nothing done. One physician whose child was attacked suddenly and with both arms and legs as well as the respiratory muscles paralyzed, and whose breathing was rap-

idly becoming worse, carried her down to his office and applied the leucodescent lamp, which gave her immediate relief. He also began at once with the static wave electric treatment, which he has kept up continually, and when I saw her she had made a remarkable gain. Using both her arms and hands, and walking very well with the aid of a light brace.

At a special meeting of the College of Physicians of Philadelphia, held October 14, 1910, and devoted entirely to this subject, I heard many good discussions. Dr. Charles K. Mills said: "I would advise the use of urotropin in the acute stages. Massage and electricity should not be used for several weeks after the onset and such treatment should be conservative in character. As a rule operative procedures should not be carried out for several months. Occasionally some kind of support to prevent possible deformity is advisable."

Dr. John K. Mitchell said: "I believe that damage is done by too early and too severe treatment. Physicians should not yield to demands of parents that something be done, but should insist that six weeks or two months be allowed before special measures are used. He should particularly avoid the ordinary mistake of allowing the child to sit up too soon. I have seen lateral curvature as the result of this mistake. Electricity should not be used under six or eight weeks, and there should be no discouragement from getting no result in the early treatment."

I believe the compromise is the better plan. Certainly the spine should be left at absolute rest during the first weeks, but I think the effected limbs should be rubbed and kept warm constantly, there is a great tendency for the affected parts to become very cold and clammy and I believe the results I have obtained, and especially the absence of the almost constant condition, of atrophy, have been due largely to the continual warmth kept up in these muscles by rubbing, etc. Early hot salt baths are stimulating. Garments made of oil silk will help keep up the warmth. I believe as much stress should be made upon not allowing the child to put its weight on its legs, as Dr. Mitchell lays upon the too early sitting up. In so doing they over-stretch also the muscles that are not affected. Care must be taken to put braces on as soon as a beginning deformity is noticed. The braces should be made as light as is possible. The question of electricity is a very open one. Some advise gal-



vanic exclusively. Others that the faradic is a nerve stimulant and exercises the muscles, and should be the only one used.

One of my friends reports good results from the use of high frequency current. I have used the static wave three times a week and I think the stimulation has done good. I also used daily both the galvanic and faradic for the localized conditions.

Every case after the inflammation has subsided should have intelligent massage at least every other day and this should be kept up for years if necessary; it is an important factor in preventing atrophy and contractions. Lastly, and probably the most important thing of all is to keep up the stimulus of the brain, the cells of the cord and the muscles themselves. This is muscle training. It must be kept up every day and several times a day and for months and years, as long as the abnormal condition lasts. The part to which the muscle belongs is put through passive movement with slow rhythm, in the direction that is desired. The patient is then directed to make an effort to move the part in the same direction to whatever extent is possible, the assistant supplying the power needed to complete the actual motion. While the patient's power may seem very small at first, it is remarkable what they can work up to.

With small children this may be done in the form of play, calling each motion by a name, such as bringing the knees together makes a pair of scissors, and the little one will try hard to cut something with the scissors. Much good is to be derived in the muscle training in the bath tub. The limbs are somewhat suspended by the water, and they are able to do things they can't do outside, and they are much encouraged.

In a recent article Dr. Max Strunsky says: "The lesion in a chronic infantile paralysis is a destruction of the motor cells in the spinal cord, while the part of the cord affected is shrunken and sclerotic.

"Improvement in the chronic stage is not due to the regeneration of motor cells in the spinal cord. The pathological law that dead organic cells never regenerate is fixed. Improvement is due to the physiologic law that cells increase in size and strength with function, and that some times a cell takes over to itself the function of the destroyed neighboring cell."

I think this is the keynote for successful treatment of these cases, and the earlier it is instituted the better.

Earlier in the paper I noted the fact that Drs. Flexner and Lewis found the germ in the mucous membrane of the nose,

mouth and throat, and also that hydrogen dioxid destroyed the germ, so I think it highly important to spray these parts with this agent. Some States quarantine this disease. New Jersey does not, but it requires them to be reported. It is wise to isolate them, and to fumigate after the acute condition is over.

Much improvement in the treatment of the deformities arising from infantile paralysis has been made of late along the line of nerve grafting, muscle and tendon transference, and the use of mechanical devises, as velocipedes, etc.

I have observed a number of cases, the onset of all has been sudden, the muscles involved in nearly all cases have been different, with varied results, even with the same nurses and treatment. One particularly interesting case in which the neck muscles alone were paralyzed, with the head rolling in all directions, unfortunately developed a contagious disease and was removed from the hospital and all trace of him was lost.

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#### THE ABDUCTION METHOD OF TREATMENT OF FRACTURES OF NECK OF FEMUR.

BY

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THE method outlined here is that which was first suggested by Dr. Whitman, of New York.

We have been taught that the average patient of sixty or over who fractured his hip,—I mean an intra capsular fracture, and escaped with his life was lucky and should be content with the disability, loss of function, loss of symmetry and go about more or less permanently crippled the balance of his life.

The old method of treating this injury by Buck's extension, fixation by T splints or sand bags, is certainly ineffective whether the patient is young or old and it fails to accomplish every one of the things desired. It does not relieve pain, it does not maintain apposition even if previously secured.

Fractures of the neck of the femur may occur at any age, the epiphyseal separation usually occurring about the twelfth to fourteenth year, especially in fat and overgrown subjects.

This fracture, as you are aware, is most frequent in the aged, especially women. Although not always recognized it is by no means uncommon at other ages.

In children, the symptoms are less severe and the actual condition is often overlooked to be recognized later in life as coxa vara in extreme degree.

In order to better understand the rationale of this method of treatment I want to review a few anatomical points. The neck of the femur projects upward, inward and slightly forward and forms an angle with the shaft of about 130 per cent. The normal range of abduction is about 45 per cent. At this limit the upper and outer surface of the neck is in contact with the projecting rim of the acetabulum, the upper part of the great trochanter lies against the ilium and the anterior and inferior portion of the capsule is made tense,—these three checks operating at the same time.

If we were lucky enough to get a bony union by the old method of treatment we usually had the angle of the neck lessened approximating a right angle—a coxa vara. Then abduction is checked by contact of the neck with the rim of the acetabulum. Adaptive changes also take place which limits motion considerably. To get a perfect result we must have (1) complete reduction of deformity, whether it be separation of epiphysis, impaction or interlocking of fragments; (2) restoration of the normal angle of the neck and shaft; (3) maintenance of fixation until no longer danger of displacement. These conditions are manifestly more difficult to secure at this joint than any other for direct manipulation of the upper fragment is impossible and apposition can only be attained by adaptation of the outer on the inner fragment. The inner fragment may lie free in the capsule attached to the ligamentum teres. When the limb is placed in extreme abduction, the upper rim of the acetabulum acts as a fulcrum in restoring the normal angle of the neck and the anterior and inferior portion of the capsule is tense and holds the two fragments in apposition.

In this extreme abducted position the muscular contraction is powerless to induce deformity. The abductors and external rotators are relaxed while the flexors, the ilio-psoas group, would tend to draw the femur directly upward and oppose rather than separate the fragments although fixation is fur-



thered more by contact of neck with the rim of the acetabulum and the trochanter against the side of the pelvis.

The method of procedure is as follows: The body and limb are covered with a well fitting union suit, from which the buttons have been removed, or a piece of seamless shirting sewed in shape. This is applied and threaded with several long bandages or scratchers designed to keep the skin in good condition. All bony prominences are protected with sheet wadding and the limb and body covered with bandage. Patient is then anesthetized and placed in position for setting the fracture and applying plaster. The head and shoulders should be supported on a box seven or eight inches high, the pelvis resting on a sacral support. A long sheet or wide clothes band is carried around the perineum, the two ends united over the shoulder and held by an assistant to furnish counter traction. Another assistant takes the well limb in full extension and abducts to the full extent, thus demonstrating the normal range of abduction; it fixes the pelvis and prevents tilting.

If fracture is incomplete the injured leg in full extension is slowly abducted to its limit. If complete the limb is first flexed and rotated to disengage any portion of the capsule that may be caught between the fragments, then gradually extend the limb. The shortening is overcome by traction and counter traction, and while the traction is maintained the outward rotation is slightly over corrected and the limb gently abducted to its full range or until the trochanter is in apposition to the side of the pelvis, the operator meanwhile pressing the trochanter downward and inward. In this position, through leverage secured and tension of the capsule, the fragments are in apposition. Measurements should be made from anterior superior spine to the malleoli to see there is no shortening. Then the plaster is applied from the toes to the mammary line.

If properly applied it is not uncomfortable and it permits the patient being turned on his side and face, to be moved to another bed or cot and carried out of doors without any danger of displacing the fragments. These old patients bear confinement badly, so it is a great advantage to get them into the open air.

Professor Lorenz, of Vienna, uses practically the same method; but instead of abducting the leg he tilts the pelvis by pushing up the well side and making traction on the injured limb and thus produces an abduction of the fractured limb

while the legs are parallel. I have seen some of his cases walking about on crutches three or four days after the injury.

This plaster bandage is kept on for eight or ten weeks, then a short spica to the knee to allow motion at this joint. At this time the patient may be up on crutches with an elevated sole on the sound foot. No weight bearing on the injured foot for four months. At the end of this time the plaster is removed and massage and passive motion started. Stepping on the injured limb must be regulated by sensations of the patient, if there is considerable weakness and discomfort from weight bearing, this warning should be heeded and a spica reapplied, which permits weight bearing without motion.

The skin is kept in good condition by wetting the scratchers with alcohol and drawing them back and forth.

The physical depression attending and following this injury is not due to the confinement alone but to being tied down on a bed with soiled linen and wrinkled sheets, to persistent pain when patient is moved or turned and the fear of pain if he attempt the slightest movement under the usual method of treatment.

In order for this treatment to be efficient it must be carefully carried out, but it gives results far superior to the older method.

These principles can be maintained and this method nearly always carried to completion. Age is a secondary consideration. Do not be afraid of breaking up impaction.

The best time for the treatment is immediately after the injury, but good results often follow after days or weeks.

Non-union is not the result of a deficient blood supply, as formerly supposed, but to faulty position or non-apposition, to ineffective fixation and to inter-position of soft parts.

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TREATMENT OF TETANUS.—Bacelli says that antitetanic serum has proven a great disappointment in the treatment of tetanus, no matter which way it is introduced into the system. Carbolic acid, given subcutaneously in sufficient dosage, is still the best remedy at our disposal. A 2 to 3 per cent. watery solution is employed. At first about 0.3 to 0.5 gm. of the acid are injected daily to test the tolerance of the patient. If the urine remains free as much as 1 to 1.5 gm. may be given during the 24 hours. Larger doses should only be used cautiously in very severe cases. According to the author's statistics, the mortality in severe cases could be reduced from 100 per cent. to 2.12 per cent., in very severe cases from 100 per cent. to 18.5 per cent. In a large percentage of the worst cases less than one gram daily was injected, so that the statistics here are no proper criterion for the action of the drug. If desired, the acid may also be injected dissolved in sterile oil.—*American Medicine*.

**GASTRIC SYMPTOMS OF CHRONIC APPENDICITIS; THEIR RESEMBLANCE TO SO-CALLED DYSPEPSIA.**

BY

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At least 80 per cent. of patients with symptoms of dyspepsia have no primary lesion in the stomach, and treatment, therefore, is usually unsatisfactory until the lesion which causes such symptoms is found and remedied. One of the most frequent causes of these gastric phenomena is chronic appendicitis.

In searching for the primary disease, a careful anamnesis is of the utmost importance; it will often disclose characteristic groups of symptoms of earlier attacks, when they were more frank and typical, or that the dyspeptic symptoms followed an acute attack, sometimes years before, as illustrated in the following case:

A. A., age 30, complained of distress after eating, could not eat any pastry, was restless at night and had severe attacks of heartburn and acid eructations, with belching and epigastric pain. The symptoms usually followed eating, especially when he ate something out of his usual fare, such as oysters or pastry. The attacks would occur at irregular times and last from ten to twenty-four hours. There was no acute pain in the right iliac fossa, nor temperature. A careful history brought out that he had had cramps about the umbilicus and lower abdomen with nausea when he was a boy, but has had none now for some years. Upon examining the abdomen, slight tenderness was found in the right iliac fossa and a diagnosis of chronic appendicitis was made. At the operation the appendix showed every evidence of chronic inflammation; it was indurated, thickened and surrounded by adhesions. He improved at once after the operation and has had no more dyspepsia; can eat anything he likes and has put on weight.

The symptoms are not always the same. Some will have epigastric pain, distention and nausea; others, sour eructations, heart-burn, belching, and still others, obstinate constipation with milder gastric symptoms, as, for instance, in the following case:

E. K., age 20, has a history of acute abdominal pain about the umbilicus and right iliac fossa, two years ago. Attack



lasted several days. Now complains of obstinate constipation, irregular attacks of epigastric pain, frontal headache, tongue coated, has no appetite and is tired and irritable; complexion sallow and has an acne which she did not have until lately. I had seen her in the acute attack, so advised the removal of the appendix. At the operation, there was found besides the chronically inflamed appendix, a ptosis of the abdominal viscera. She has improved since the operation, become stouter, complexion has cleared, and, with at first an abdominal support, and later, appropriate exercises for the abdominal muscles, she has largely regained her health.

In some cases the attacks occur every three or four weeks and become so persistent and severe that they interfere very seriously with the patient's livelihood, which was the condition in the following case:

J. F., age 29, motorman, has had for number of years what he called "stomach trouble." He would be fairly well for a time, but about every three or four weeks, would have attacks of epigastric pain and violent vomiting; which became so severe that he was forced to give up his work for the time. He was thin and highly nervous. There were no local symptoms and no fever, but when I examined him, I found upon firm, deep pressure in the right iliac fossa, that the right rectus became suddenly rigid. The muscles were soft upon ordinary pressure. He consented to an operation and the appendix was found low in the pelvis, buried in adhesions and at its tip there had been at some time, probably years before, a perforation, which had been protected by a portion of the omentum, which was still adherent. After it was teased away in the laboratory, the perforation, about 6 mm. in diameter, could be plainly made out. There was no pus present. He left the hospital in good condition and has been well since. I could not get a history of the acute attack from him.

In some cases, neurotic symptoms predominate. We should be on our guard in this class of cases, not to diagnose neurasthenia until every other possibility has been thought of; for we must bear in mind that often such symptoms are caused by a chronic lesion. The further one gets away from the diagnosis of gastric neuroses, the nearer the correct diagnosis he is. The following case serves as a type of this class:

J. McL., age 28, complained of abdominal pain which was usually about the umbilicus, no marked tenderness at McBur-

ney's point. The attacks would appear some times twice a week and then again not for two or three weeks. He would be nauseated, have no appetite and what little he ate caused him pain and a sensation of fulness in the epigastrium; he was also constipated; there was no temperature. He was very much depressed and hypochondriacal; did not think he could be cured and complained of tenderness wherever he was examined over the abdomen. He had been to a number of physicians who had diagnosed the case as gastric neuroses. Believing that the attacks were of appendiceal origin, I opened the abdomen and found the appendix inflamed and placed retroperitoneally. It had never entirely descended from its fetal position, but a third of it was adherent to the posterior muscles just below the kidney, and the cecum was curled on itself and held somewhat higher at the ilio cecal junction than normally and dragged on the attached appendix. There was also ectopia of the testicle on the right side. After the operation his attacks of pain and nausea stopped and he has gone back to his occupation in good condition.

We must bear in mind that the appendix, although found in the right iliac fossa generally, may be displaced, as in the case just cited. It may also be on the left side, or low down in the pelvis; it may some times be in the inguinal canal and even in the femoral. I have just operated a case of femoral hernia containing the appendix, which was strangulated and as most of the symptoms were referred to the epigastrium, I will report it here:

L. B., female, age 45, had a cough (reflex) for a number of years. Cough would come on spasmodically and a week ago in one of the attacks, she suddenly began to vomit, which persisted for two days with sharp shooting pain in the lower part of the abdomen. She first felt the hernia two days after the vomiting ceased. This was because it had begun to be inflamed, as no doubt it had been there, from the history, for some time and became strangulated in the severe attack of coughing. Two days before the operation she had no vomiting, very slight nausea and a dull pain in the femoral region; was constipated, had no distention nor acute pain and the temperature was normal. The operation disclosed a dark and engorged part of gut, which was found to be the end of the appendix. It was constricted about one and a half inches from its tip. The cough, which was reflex, cleared up after the operation.

In chronic recurring appendicitis, there is very little appendiceal tenderness; often no pain at McBurney's point, no temperature, no symptoms of a frank appendicitis. There may be pain at times in the epigastric region extending to the umbilicus and lower abdomen, with gas, acid eructations, pyrosis, nausea and vomiting, but these symptoms do not occur at the same time, but come earlier or later and may be moderate at one time and severe at another, but symptoms of an impaired digestion are nearly always present; i. e., bloating after meals, coated tongue, constipation, lassitude and the patients are often thin and irritable.

The symptoms are some times so pronounced that they resemble duodenal ulcer, but there is not the regularity of the pain which is relieved by eating, the so-called "hunger pain" which is found in ulcer. It generally occurs about two hours, some times later, after the meal. The patient will often be comparatively well between the attacks and apparently the ulcer tends to heal during the intervals, but usually becomes active again, often in the spring or fall of the year.

In duodenal ulcer there is always at some time, blood in the stools either occult or in large amount and it is fairly constant when it occurs. The following case illustrates the characteristic symptoms of this affection:

J. B., female, age 62, has had for years what she called "bilious attacks." They would start with pain about the abdomen and then extend to the epigastrium. There was belching and sour eructations and vomiting. These symptoms would generally occur about two and one-half hours after meals. There was a marked regularity about them, and eating a biscuit or drinking a glass of milk would give relief. The attacks would last for several weeks and then subside and she would be fairly comfortable until the next one. She had been in the hospital the previous spring with acute symptoms. During the present attack, occult blood was found in the stools, and tenderness upon deep pressure to the right of the mid-line. She was very much emaciated and prostrated. A diagnosis of duodenal ulcer was made and a posterior gastroenterostomy performed. She had a large indurated ulcer. She improved at once and I heard from her physician a few days ago that she is entirely well and can eat anything. The so-called bilious attacks in this case meant ulceration, although she had been treated for years by various physicians for dyspepsia.



These symptoms differ from those of appendiceal origin. There is a regularity about them. In chronic recurring appendicitis the pain may come at any time and is often times made worse by food, and in the interval between attacks, there are more symptoms, such as fulness after meals, constipation, loss of appetite and some times nausea.

Gall-stone disease may resemble chronic appendicitis. There may be epigastric pain, bloating after meals, dull aching in the epigastrium and in the region of the umbilicus, but the pain often extends to the right costal arch and is increased by food, exertion and deep inspirations, and there is a history of acute attacks with sudden cessations and occasionally there may be jaundice. The gall bladder is usually tender. This can be best recognized by sinking the fingers well under the right costal arch as the patient exhales; as a deep inspiration is made, the tenderness will be apparent when the gall bladder comes in contact with the examining fingers and the inspiration will often stop short with a jerk.

Chronic gall bladder disease is usually discovered later in life and the patients are often stout. The following case is a closely typical one:

E. Y., female, age 45, stout, has had symptoms of indigestion for some years. For the last two years has had attacks of pain in the epigastrium, occurring about every six weeks to three months. The pain started in the epigastrium and then located on the right side along the right costal border and extending down to the level of the umbilicus in front, and the right loin in the back, and at the height of the attack she would vomit. During the intervals she had at times nausea, dull epigastric pain extending to the right costal arch; full, tense sensation in abdomen after eating which belching somewhat relieved. Upon examination the gall bladder was found to be tender when deep pressure was made and there was some rigidity of the right rectus muscle, more at its upper part. There was no jaundice. At the operation, the gall bladder was found thickened, turgid and contained thick muco-purulent fluid and a number of stones. While these symptoms of dyspepsia caused by pyloro-spasm are associated with various lesions, yet the grouping of the symptoms and the predominance of some, together with those that point more directly to the real cause, will help us to differentiate. We must remember also that some times there may be multiple lesions which can only be clearly understood at the time of operation, but you will always have enough symptoms to justify such an exploration.

## EDITORIAL

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### INSECTS AS CARRIERS OF DISEASE.

THE fact that contagious diseases are often disseminated by means of insects has been thoroughly established by numerous investigators during the past decade.

The return of the summer season reminds us that in temperate climates there are two classes of insects that play an important part as disease carriers, namely: flies and mosquitoes.

The researches of Torrey, of the Loomis Laboratory of New York City, have shown that, as the warm season advances the number of bacteria found on flies markedly increases and the types of bacteria found during the months of July and August are of a much more serious character from a sanitary standpoint.

A single insect may carry an enormous number of microorganisms. Torrey found that in some instances the number of bacteria on the surface of the insect amounted to more than four million, and as high as twenty-eight million were found in the intestinal contents.

The most important disease disseminated by means of the house fly is typhoid fever. It has been pretty conclusively shown that the majority of cases of typhoid fever in the United States Military Camps during the Spanish War of 1898, were the result of contamination of the food by means of flies. In civil life it is probable that the dissemination of typhoid fever by means of flies is not so common except, perhaps, in rural districts where very inadequate facilities for the disposal of sewage exist. In addition to typhoid fever there is no doubt but that the fly plays an important part in the spread of cholera, various forms of dysentery, diphtheria and contagious forms of conjunctivitis. Some have thought that cerebro-spinal meningitis and anthrax may also be transmitted by flies.

There are two means whereby the danger of contamination of food by means of flies can be eliminated. First, by the use of screens in the house, and, second, by carefully disposing of

all forms of filth that tend to accumulate around the household. It has been shown that flies breed principally in filth and if decayed vegetable matter, garbage cans, sewage, etc., are properly destroyed or protected by means of covers, the number of flies will be decidedly diminished. It is a rather hopeless task to attempt to kill off flies if we do not destroy their breeding places. The fly is notably prolific, and, even the destruction of seven million flies, as was accomplished last year in Washington, D. C., is but a small matter as compared with the total number that are bred each year. It is far better to begin at the beginning and to prevent the propagation of flies rather than to attempt to destroy them after they have reached maturity.

The mosquito is another insect that plays an important part in the propagation of disease in the United States. We are chiefly interested in the genus *anopheles* which is the intermediate host for the malarial parasite, while in tropical countries another species of mosquito, the *stegomyia calopus*, is of equal interest on account of it being the medium of transmission of yellow fever.

Mosquitoes are rapid breeders and pass through their earlier stages of development in the water. Most species pass through several generations in the course of a summer, developing in rain barrels, cesspools and various other places where stagnant water exists. In the winter the adults hibernate in bark of trees, in old boxes, in out-buildings and in the cellars and attics of houses. The life of the mosquito is short, but they propagate very rapidly. The majority of mosquitoes do not seem to be strong fliers and it is seldom that *anopheles*, in particular, is found more than half a mile away from its breeding place.

The species of mosquito found most frequently in the Northern and Central states are the *culex* and the *anopheles*. The *culex* as far as we know is not responsible for the carriage of any disease. The *anopheles*, which is the chief disease-carrying mosquito of temperate climates, can be distinguished from the *culex* by the fact that the palpi in both sexes are about as long as the proboscis; the body colors are brown and yellow and the wings are usually spotted. The members of the genus *anopheles* can usually be readily recognized when at rest by the fact that the body, head and beak are held in practically the same plane, whereas there is a marked angle between the body and the head and beak in most other mosquitoes. As a rule,



the anopheles bite only after nightfall, but at least one member of this genus will bite during the day. Differing from every other species of mosquitoes the anopheles make every effort to enter houses. They usually hibernate in cellars, barns or other out-buildings. Their eggs are laid upon the surface of water and are usually found in little groups. These eggs hatch in from three to four days in warm weather. The larva remains near the surface of the water with its breathing tube projecting into the air. The duration of the larval stage is from sixteen to twenty days, then this period passes into the pupal stage which lasts from three to ten days. The minimum duration of a generation in summer time, from egg to the adult mosquito, requires about twenty days. This period may be extended indefinitely by cooler weather.

The anopheles are present in low lying districts and are seldom found at an altitude of more than 1,000 feet. The distribution of the genus is very wide, it having been found throughout all sections of the United States and in many parts of Europe.

The best remedy against mosquitoes, as well as against flies, is the destruction of their breeding places. In localities where extensive marshes or swamps exist, it is necessary that they should be drained or covered with petroleum from time to time. In localities where the land is better drained, every householder is practically responsible for his own mosquitoes as the majority of them are bred on his own property. It is necessary in order to eradicate them that every possible receptacle for standing water should be abolished or filled in. Cesspools should be covered or should be treated occasionally with kerosene. Tin cans and old bottles, rain barrels and even roof gutters which are apt to become blocked and thus afford a resting place for water, should be attended to. Ponds which cannot be drained should be treated with petroleum oil or should be stocked with minnows and other forms of fish.

In communities where the people have been aroused to the importance of this work and have seriously endeavored to carry out instructions above referred to, the mosquito nuisance has been markedly abated and in many instances these pests have been entirely abolished. It was work carried out along these lines that transformed the Canal Zone at Panama from a veritable pest hole of fever into one of the healthiest communities in America.

G. H. W.

**THE REPORT OF THE BOARD OF MEDICAL EXAMINERS.**

ON page 417 of the present issue of the HAHNEMANNIAN MONTHLY will be found a complete report of the work of the Board of Medical Examiners, representing the Homœopathic Medical Society, during its eighteen years of existence, from 1894 to 1912.

The report covers every detail of the work done by the Board and the profession is certainly indebted to the Secretary of the Board, Dr. Joseph G. Guernsey, for the care with which he has compiled the statistics which set forth briefly and accurately the work of the Board.

Many of our readers will recall the bitter opposition on the part of a large number of physicians to the passage of the Act authorizing the appointment of the Board of Medical Examiners in 1893. It was claimed that such an act would be an infringement on the personal rights of individuals who desired to enter upon the practice of medicine and that it would give into the hands of a few men an arbitrary power which they could use unjustly in excluding from the practice of medicine such individuals as did not meet with their personal approval. It is but fair to say that all of these fears have proved to be unfounded. In looking back over the work of the Board during the past eighteen years, it is doubtful whether a single case could be cited in which an applicant has not received fair and just treatment from the Board. It is to the credit of the members of the Board that their conduct was such as to silence all just criticism and that as a result of their work the standard of medical education in this state has been steadily and decidedly advanced.

It is of interest to know that during the existence of the Board, 971 applicants were examined, of whom 859 (88.47 per cent.) passed the examination. Of these 971 applicants, 735 were graduates of the Hahnemann Medical College of Philadelphia, and of this number, 680, (92.51 per cent.) passed, being about four per cent. higher than the average percentage of successful applicants from all of the colleges represented.

On January 1st, 1912, the old Board of Medical Examiners ceased to exist and the new Bureau of Medical Education and Licensure, appointed by the Governor during the past year assumed the duties involved in granting licenses to practice medicine and surgery in the State of Pennsylvania.

The principle of state regulation of medical practitioners is now thoroughly established and with the advantage to be obtained from the experience of the former Board of Medical Examiners, there is every reason to expect that the new Bureau will carry on the work that has been so well begun and will play an important part in the advancement of medical teaching in this state.

G. H. W.

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### A COMMUNICATION.

TO THE EDITOR.

In the March number of the *HAHNEMANNIAN* you published a paper which I read before the Woman's Homœopathic Medical Club and through some misunderstanding between yourself and the Club, and without my consent, the title was changed to read "A Fragmentary Report on One Hundred Laparotomies."

While most of the cases in this series were laparotomies, there were some that were not, as the text shows, and the original title did not contain the word "laparotomies."

I mention this fact because I do not like to be placed in the position of seeming to brag of my operative mortality, and while most surgeons can show a series of one hundred laparotomies without a death, still we are all aware that the next series may contain quite a mortality, according to the nature of the cases and the number of "surgical accidents" which we are all liable to meet.

Dr. Maurice Richardson has said: "The surgeon who claims he does not make errors either does not do surgery, or else he is untruthful," and I would say the same thing of the surgeon who says he has no mortality in abdominal surgery.

Sincerely yours,

N. F. LANE, M. D.

1925 Chestnut Street, May 28, 1912.



## GLEANINGS

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PRESENT STATUS OF 606.—Robinson, in the *Critic and Guide*, thinks the best, most thorough, most painstaking and most unbiased review of the present status of the treatment of syphilis with 606 is that of Prof. E. Tomaszewski, of Berlin, a translation of which appeared in the March issue of the *American Journal of Urology*. We append here the conclusions arrived at by Professor Tomaszewski.

1. A single intramuscular or subcutaneous injection, possibly a repeated intravenous injection, certainly a combined intravenous and intramuscular injection of a sufficient amount (0.5 to 0.6 gm.) of salvarsan produces marked symptomatic effects in cases of malignant syphilis, often effects of very long duration, and not infrequently saves life in these cases.

2. Salvarsan treatment attains the value of an energetic mercurial course (calomel injections) in all other types of syphilis, with relatively rare exceptions.

3. It is possible that a permanent cure, a *therapia magna sterilisans*, may be effected early in the primary stage, but undoubtedly most of these cases remain clinically and serologically free from symptoms for a long period.

4. In cases of syphilis in any stage in which mercury was not tolerated, or very badly borne, or in which new recurrences appeared in spite of repeated courses of mercury, salvarsan almost invariably produced excellent results—if not permanent cures, at least cures lasting a long time.

5. Salvarsan produces certain local, more or less severe tissue changes in all cases except when used intravenously, and it gives rise to a series of untoward general effects no matter what mode of administration may be used. These untoward effects vary greatly in character and intensity in different individuals. Untoward effects of serious nature have thus far been noted in a very small proportion of cases after a single injection, and in some of these cases, they were referable to faulty technique or some other preventable cause.

6. We must continue to employ the chronic intermittent treatment of syphilis and must maintain as before, the necessity for a complete course of treatment in deciding such questions as transmissibility, consent to marriage, etc., in every case.

7. All our experiences thus far (indications, contraindications, etc.), are essentially based upon single salvarsan injections; and we, as yet, know practically nothing of the action and untoward effects of a chronic intermittent salvarsan treatment.

8. Neither an injection nor an infusion of salvarsan excludes a simultaneous or subsequent course of treatment with mercury or iodides, but,

on the contrary, the special therapeutic effects of these three remedies may be happily combined.—*The Medical Standard*.

EHRLICH ON 606.—At the recent meeting of the *Deutscher Naturforscher und Aerzte*, Ehrlich gave a digest of the present status of arsenobenzol therapy (*Deutsche Medizinische Wochenschrift*, October 19). From the very beginning of his efforts he investigated the possible unpleasant collateral action of the remedy, and every legitimate announcement which emanated from the experience of others touching upon the hostile activity of the drug has been debited for the time to the account of the latter. Certain curiosities of medical practice have come to light in this endeavor. One case of death supposedly attributable to salvarsan turned out to be a homicide. Some persistent after effects, such as bladder troubles, were due, Ehrlich thinks, to decomposition of the drug from contact with the air. Painful indurations at the puncture, venous thrombosis, and other local sequellae were due, in his belief, to defective technique in preparing solutions. Much of the headache, vomiting, diarrhea, etc., reported after injections of the remedy might have been due to the bacterial content of the distilled water employed! The auditory and other disturbances of special sense seem to have occurred in subjects predisposed thereto by previous attacks. In fact, few of the untoward symptoms following the use of 606 could justly be attributed to the action of this drug, according to its discoverer. Ehrlich's remedy seems to be gradually establishing itself as a panacea, for he claims that it is essentially curative in syphilis, fowl spirillosis, recurrent fever, yaws, tertian malaria, Aleppo boil, bilharziosis, the pneumonic plague of horses, and African farcy. He failed, however, to mention the alleged curative power of the drug in typhus fever and the bubonic plague, and he went so far as to admit that it has no power over kala azar.—*Medical Record*, January, 1912.

MUCOUS COLITIS AND SPASTIC CONSTIPATION.—Hubert Higgins, in discussing the diagnosis and treatment of these conditions, states that it is generally easy to examine the colon from the cecum to the hepatic angle, as well as the descending colon. The transverse colon can only be defined when it is either contracted or filled with feces. In examining for it two methods are useful: (1) that of Glenard, which consists in carefully placing the soft part of the four fingers of both hands midway between the umbilicus and ensiform cartilage and pressing them downward toward the umbilicus, when the contracted colon can be felt to give the sensation of a tense cord; (2) grasping the trunk with the two hands and palpating with the thumbs, to ascertain whether there are retained feces. The pelvic colon can only be satisfactorily examined per rectum or bimanually. A useful test for coprostasis is to give a large quantity of charcoal before a meal. Normally it will be discharged in twenty-four hours. In some cases it will be from forty-eight hours to several days before it appears, even though there is a satisfactory daily action; on the other hand, it may not cease to blacken the feces for several days.

In the treatment, whenever there is either weakness or want of tone of the abdominal muscles, even without visceroptosis, it is necessary to pre-

scribe an elastic belt, supporting the abdomen immediately above the pubes; this should be combined with exercises. A belt is especially necessary in the obese. When systematic dieting is being carried out nothing but a thorough daily evacuation is of any use; to know whether it is complete the charcoal test or an examination of the product of a water enema may be employed, and further information is obtainable by urinary analysis.

Where the feces are too dry, salines, with or without agar-agar or regulin, give the best results. The author has repeatedly verified Glenard's observation that a saline draught in cases of insomnia during the early morning hours will often bring on sleep. Where energetic means are used to cause evacuation of irritating and spasm-producing materials—inspissated mucus, membranes, sandy material, etc.—in mucous colitis, the slow and painful passage of these substances will give trouble for four or five days. Osgill pills should always be given when there is pain, as they help dissolve adherent, coagulated mucus. Oil enemata are indispensable, facilitating progress of the material in the bowel.—*Practitioner*, February, 1912.

THE TREATMENT OF TUBERCULOSIS OF THE KIDNEY.—At the last meeting of the German Urological Society an interesting discussion took place on the treatment of renal tuberculosis which resolved itself into a comparison of the relative merits of conservative and operative methods (*Zeitschr. f. Urologie*, 1912, Vol. I.).

At the sitting where tuberculin treatment was specially discussed the following conclusions were formulated by Bachrach, who introduced the subject: 1 Operable cases of renal tuberculosis are not suitable for tuberculin treatment. 2. Early cases where bacilli are found, without marked suppuration or interference with kidney function, may be treated with tuberculin till a definite indication for nephrectomy arises. 3. After nephrectomy tuberculin treatment is advisable if tubercle is present in the genital tract or elsewhere. 4. Tuberculin treatment results in improvement of the general health. 5. Definite cure of local deposits has so far not been proved. 6. Tuberculin treatment must be carried out so as to produce no reaction. 7. Inoperable cases of renal tubercle are not appreciably influenced by tuberculin, although the treatment may be tried in the absence of any other therapeutic measure likely to be of assistance.

Other speakers agreed substantially with these conclusions, in particular that tuberculin treatment was not to be regarded as a substitute for the operative treatment of renal tuberculosis.

In the discussion on the results of nephrectomy for tubercular kidney, Wildbolz emphasized the difficulty of arriving at definite conclusions with regard to the results of conservative treatment owing to the very inconclusive nature of the reports available for study, and stated that genuine cases of permanent recovery in which the urine has become healthy and both kidneys have been found to functionate normally are not to be found in the literature. He maintained that numerous reported cures after tuberculin treatment had all been reported too early to allow of a final verdict being arrived at.

In order to arrive at a definite finding he obtained information from a large number of medical men, which yielded 316 cases bacteriologically ex-



amined and proved to be tubercular. Two hundred and eighteen of these, i. e. 70 per cent., had succumbed to the disease within five years of its onset. Only 30 of the 98 surviving cases were free from marked symptoms, and in this connection he pointed out as a noteworthy feature that among the fatal cases a number had shown apparent cure for months or years till the disease reappeared and proved fatal. In addition to these 316 cases, all treated by conservative measures, Wildbolz carefully investigated his own records and those of a colleague which showed very similar results. His investigations led him to summarize as follows: Under conservative treatment the majority of cases die within five years. Rather more than 20 per cent. of cases survive more than five to ten years, a few even longer. In a small minority of cases the symptoms practically disappear, so that the patients might be regarded as cured did not a thorough examination of the urine and the eventual reappearance of symptoms prove the contrary. An apparently genuine lasting cure has only been noted in isolated cases out of thousands reported, and these are too few to invalidate the statement that tuberculosis of the kidney is not curable, as a rule, by conservative measures in use at the present time.

On the other hand, the results of operative treatment show a high percentage of cures. Israel, speaking from a study of 1,023 cases, claimed 75 per cent. of cures. 12.9 per cent. of the deaths took place within six months, the remainder mostly within two years after operation. His mortality was higher in males than in females. The chief cause of the deaths occurring soon after operation was miliary tuberculosis; of the later deaths, phthisis and disease in the remaining kidney.

Wildbolz's own material showed 60.8 per cent. of cures, and in general it appeared from the results reported by a number of observers that well over 50 per cent. of cures are obtained by operative treatment.

As regards proof of cure, it may be noted that Israel, Casper, and others regard the results of inoculation tests as the only reliable means of proving the absence of tubercle bacilli from the urine, for bacilli may be found in urine which on ordinary examination appears healthy and free from albumin.—*Edinburgh Medical Journal*.

CARDIOVASCULAR DEGENERATION.—Bruce, in *The London Lancet*, takes up the influence of nervous, intellectual, and emotional stress, also the question of arterial degeneration in women. Treatment includes the consideration of syphilis, glycosuria, gout, physical strain, and nervous stress. His remarks on treatment may be summarized as follows: If we review the indications which we have found under the different kinds of cardiovascular degeneration, the subject of treatment appears in a more satisfactory light than when it is regarded from the point of view of a single substantive disease. The result in many instances is good for a time. The nutrition of the cardiac and vascular walls improves, and pressure is kept within moderate bounds, and thus the natural resistance and provisions for compensation with which the organs of circulation are endowed are successfully maintained. The management of the case now consists in retaining the control which we have gained of the cause of the disease, and in resisting as long as possible the growing dangers for which we must be prepared, as we have seen under prognosis. Whatever its origin,

degeneration is essentially progressive—slowly or rapidly. The patient is past his prime; treatment must be carefully adapted to the circumstances of advancing age. The original cause may be still at work, as in gout, or it may be dormant only. Specific measures cannot always be safely omitted. The patient is beset by the incidental circumstances and events of life—professional, social, and domestic—causes of occasional embarrassment and distress threatening compensation, whether by affecting the nutrition of the walls or by raising the blood pressure. The syphilitic subject develops gout or nephritis. The glycosuric subject meets with misfortune in business, or he is tempted to eat heartily again, and narrowly escapes death in an attack of paroxysmal dyspnoea. The gouty man foolishly taxes his enlarged heart in a fit of determination to cure himself with active exercise. Here we see necessity for observant supervision of the patient's whole manner of living. It is surprising how largely success in treatment, like success in prognosis, depends on a correct appreciation of these secondary causes of cardiac embarrassment. A man believed to be dying from acute failure of the heart and pulmonary oedema, in this stage of cardiovascular degeneration, has been rescued by active purgation and temporary starvation. But meanwhile vicious circles form and increase in area and in number, slowly but steadily sapping the nutrition and vigor of the heart. Degeneration of the heart and vessels once commenced, necessarily advances and ends in death. For a time treatment is so far successful as to retard the progress of disease and prevent or relieve disorder and distress. But sooner or later it ceases to benefit; and if the patient does not perish suddenly, or from cerebral hæmorrhage or Bright's disease, or in one or other of the ways which we noticed in connection with the different causes, treatment comes to be required in a new direction—for failure of the heart. Even now it is incorrect to neglect entirely the original cause of the disease. But by this time, as a rule, the condition of the patient is too complex for much good to be expected from dissociation of its elements—the primary degeneration, the effects of additional causes of disturbance, the widespread involvement of the circulation and viscera in vicious circles. But the principle that has guided us throughout this study is still to be followed. Failure of the heart must have an immediate cause, and this often can be discovered and dealt with successfully, for temporary recovery is still not impossible. Cardiac dropsy not infrequently yields to rest, correct diet, faithful nursing, and well planned medication in these cases of old degenerated hearts and sclerosed vessels. Even now it is not always too late to use digitalis or its allies; the circulation may still respond to them. At least there is an end to the success that so often rewards a rational view of the nature of cardiovascular degeneration, and the therapeutical management of it on rational principles. Little can be done now but to try to secure euthanasia for a patient dying with cardiac and respiratory distress; to order diet and hypnotics, and, most difficult of all, to make proper use of morphine, to afford what relief we can to the heart which has been maintaining a brave fight against great and ever growing evils for so many years.—*Charlotte Med. Jour.*

THE PROSTATE IN CHRONIC GONORRHEA.—Willard states that in sixty to ninety per cent. of all sub-acute or chronic gonorrheas the prostate is in-

fect and that microscopical examination of the secretion is the only reliable method of determining whether infection is present or not. Palpation alone is often misleading. A slight morning drop and a few threads in the urine may be the only signs a patient may have, whose prostate has been infected for years, later to be lighted up by intercourse or drinking. Many of the patients suffer from pain in the back, loins, thighs, pubic region, or testicles, or are neurasthenic and impotent. Sterility may be present, the spermatazoa being killed by pus or absence of lecithin. Prostatitis may be catarrhal, follicular, parenchymatous, or phlegmonous. In catarrhal prostatitis pus germs eliminate the gonococci and keep up a low grade inflammation, with perhaps a slight amount of clear secretion, but excesses do not set up a profuse discharge, although indefinite pain and sterility may be present. The secretion contains numerous scattered pus cells and a few lecithin globules. In follicular prostatitis soft areas can be palpated. Frequent micturition and pain at the end of miction are complained of. The secretion shows fields of normal secretion surrounded by others full of pus cells. In parenchymatous prostatitis all the secretory portion is affected and the gland feels tense on palpation. The secretion is abundant and full of pus. Fever and constitutional symptoms, with difficulty in defecation and urination, will likely be present. Single or multiple abscesses may be present in the phlegmonous form and the gland partially or wholly destroyed. The pus may invade neighboring structures or follow the cord. Massage of the prostate is the most important part of the treatment, but should never be done if the gland is acutely inflamed. Instillation of thirty minims of one-half to two per cent. silver nitrate solution is better than large injection of weaker solutions, and more effective than the newer silver salts. Treat the patient twice a week, and inhibit alcohol, intercourse, strenuous exercise, and condiments during treatment, and for a few weeks after it stops.—*New York Med. Jour.*

AN ANTI-SERUM FOR CANCER.—A new anti-serum for cancer was recently reported by Berkeley and Beebe to the New York Academy of Medicine. In the paper, which was only a preliminary report (*Med. Rec.*, March 16), the authors give these findings:

1. By successive injections of a specific human cancer extract (the cancer being partially removed by operation) into an alien mammalian species it appears that a serum may be developed which, when injected intramuscularly, or better, intravenously, in increasing doses into the original host, is followed by rapid regression and disappearance of the remains of the tumor. This cannot be done with a normal alien serum. It is hard to explain the phenomenon except as a cytotoxicity of the tumor cells.

2. There is a strictly quantitative relation between the amount of serum used and the amount of tumor which may be made to disappear.

3. No ill effects have been so far observed from the injections of the serum (16 cases), except local swelling and the anaphylactic fever and vasomotor disturbances noted after giving an equal amount of normal foreign serum.

4. The relation of one anti-serum ("stock serum") to histologically different cancers is variable and full of surprises. It will take years of labor to determine all the curious chemical affinities that may be involved.



5. Present clinical results are briefly as follows: Sixteen cases of malignant disease in all stages of advancement have been treated in the last nine months. A microscopical diagnosis was made in all but three cases. Fifteen were cancer and one was sarcoma. Nine received stock serum, one received autogenous serum after a secondary operation, six received autogenous serum after a primary operation. Of the nine patients receiving stock serum two were moribund when first seen, and died quite uninfluenced by the injection; another, having cancer of the esophagus, was remarkably benefited for several weeks; one, with an immense cancer of the tonsil, was somewhat benefited temporarily. One very extensive primary cancer of the bladder has not been recently heard from, but was probably not benefited. Of two immense cancers of the stomach, one was entirely unaffected, one slightly improved. One patient (breast case), after two months of injections, is nearly well and in excellent general condition. Another case (uterine cancer recurrent in the bladder) recovered promptly and has remained entirely well for four months. One far advanced breast case receiving a small amount of autogenous serum after a secondary operation, was greatly improved, but subsequently died of intercurrent acute disease. Of the patients receiving autogenous serum after a primary operation one is still under treatment, greatly improved; the others have had no recurrence within a period ranging from three to six months.

The present impression of the writers is that autogenous serum is much more effective than stock serum. It is believed that the great field of usefulness of the new serum will be to prevent the recurrence of malignant tumors removable in the early stages by operation.

There is no indication from present experience that large inoperable cancers and sarcomas will be amenable to the serum treatment. Treatment, to be effective, must be early if there is to be any reasonable quantitative relation between tumor and antibody. This report is hopeful and it is apparent that some of the many investigators in the cancer field will eventually discover a specific.

Great hopes are entertained that Ehrlich and Wassermann, working, as they are, in conjunction, will have a definite report of real progress in discovering a specific for human cancer, as they have for mouse cancer, before the end of 1912.

DISINFECTING PROPERTIES OF THE MORE COMMONLY USED DISINFECTANTS.  
—Bichloride of Mercury:—1 part in 1,000,000 nutrient gelatin or bouillon prevents the development of parasitic bacteria. In water 1 part in 500,000 will kill many varieties in a few minutes. With organic substances its power is diminished so that 1 in 1,000 may be required. Most spores are destroyed within an hour when placed in 1 to 1,000 watery solution. We see, therefore, that the presence of organic material diminishes the efficiency of mercury as a disinfectant. The cause of this lies in the fact that mercury in alkaline fluids containing much albuminous substance forms insoluble compounds with the albuminous substances. Thus when mercury is brought in contact with a mass of fecal material, it forms an insoluble coat about the mass and thus prevents the disinfectant from penetrating further. Therefore, mercury is not a good disinfectant to use for disinfecting sputum or stools. The precipitation of the insoluble salt can be

prevented by adding suitable quantities of sodium chloride (table salt) and ammonium chloride. The tablets of bichloride generally used have this combination for that reason. Solutions of 1 to 500 and 1 to 1,000 are sufficiently strong, when brought in contact with the bacteria, to kill the vegetative forms in fifteen minutes. When much organic matter is present stronger solutions must be used.

**Nitrate of Silver:**—In solution it has about one-quarter the value of bichloride of mercury as a disinfectant, but in inhibiting growth it has nearly the same value. In severe infections of the eye, as for instance gonorrheal, silver nitrate is used as a disinfectant for the conjunctiva.

**Gaseous Disinfectants:**—Sulphur, when burned, produces  $\text{SO}_2$  gas. This gas is a much more active germicide in a moist than in a dry condition. An exposure for eight hours to an atmosphere containing at least four volumes per cent. of this gas in the presence of moisture will destroy most, if not all, of the pathogenic bacteria in their vegetative form. Four pounds of sulphur for each 1,000 cubic feet gives an excess of gas.

**Peroxide of Hydrogen:**—By virtue of its loosely combined oxygen, in a 20 per cent. solution will quickly destroy the pyogenic cocci and other spore free bacteria.

**Chloride of Lime:**—Depends on chlorine for its efficiency. A watery solution of 0.5 to 1 per cent. of chloride of lime will kill most bacteria in 1 to 5 minutes. A 5 per cent. solution usually destroys spores within an hour.

**ORGANIC DISINFECTANTS.**—**Alcohol:**—Ten per cent. strength of alcohol inhibits the growth of bacteria. Absolute alcohol (that is practically 100 per cent. alcohol) kills the vegetative forms of bacteria in from several to 24 hours.

Formaldehyde is a gaseous compound. Commercially it occurs in 40 per cent. solution. The most delicate silk, woolen, cotton, fur, and leather materials are unaffected in texture or color by formaldehyde. Only certain aniline colors as fuchsin and safranin are affected; but these need not be considered, as they are not used in fabrics on account of their liability to fade. Iron and steel are attacked after long exposure to the gas, but copper, brass, nickel, zinc, silver and gilt work are not acted upon. From these facts we see that formaldehyde is a very valuable disinfectant for dwelling places. It is also a good destroyer of odors. By experiment it has been found that in the air a 2.5 per cent. by volume of the aqueous solution or 10 per cent. by volume of the gas destroys fresh virulent cultures or the common pathogenic bacteria in a few minutes. Its action is more rapid and complete at higher temperatures and when the air is moist. Vegetative forms of bacteria are destroyed by a 2 per cent. watery solution of formalin within five minutes. Experimentally, formalin has been found to have half the strength of pure carbolic acid in effect on vegetative forms of bacteria.

**Chloroform:**—Even in 1 per cent. solution chloroform destroys vegetative forms of bacteria. It is used to sterilize blood serum used for culture purposes, as it can be evaporated after it has had its effect.

**Iodoform:**—Has no appreciable destructive effect on most varieties of bacteria. It prevents decomposition and inhibits the growth of germs of putrefaction, and pus formation, but does not destroy them.

Aristol, a reddish brown powder, containing about 45 per cent. of iodine is used as a substitute for iodoform. It has a less disagreeable odor and is less poisonous.

Carbolic Acid:—One part in 1,000 inhibits the growth of bacteria; 1 to 100 kills all vegetative forms of bacteria. The less resistant spores are killed by a 5 per cent. solution within a few hours and the more resistant in from one to four weeks. Carbolic acid has the advantage over bichloride of mercury in that it does not form an insoluble compound with albumin when brought in contact with organic matter and is therefore more penetrating. Furthermore, it does not discolor instruments nor clothing as bichloride does, but it irritates and benumbs the skin when used in disinfecting the hands. There are a number of disinfectants in common use that are made with cresol, the main ingredient of "crude carbolic acid." Among them are creolin and lysol. The former is used in 2 per cent. to 5 per cent. strength for cleansing hands and for irrigation. Lysol is used in surgery and gynecology in 1 per cent. to 5 per cent. strength; two and one-half teaspoonfuls of either to a quart of water makes about a 1 per cent. solution.

Boric acid, used in a saturated solution, is a mild, non-irritating and practically non-poisonous antiseptic. Thiersch's solution is a solution of boric acid with salicylic acid added. It contains two parts of salicylic acid, 12 parts of boric acid to 1,000 parts of hot water. It is a non-poisonous, non-irritating antiseptic of moderate power.

Potassium permanganate is an antiseptic, a disinfectant and a deodorant. It acts by parting with its contained oxygen and then becomes inert. It has a reddish purple color and then changes to brown when it has ceased acting. It has the disadvantage that it stains a brownish black color. It is used in solutions varying in strength from 1 to 100 to 1 to 10.

PRACTICAL DISINFECTION AND STERILIZATION.—Sunlight, pure air, and cleanliness are always very important agents for maintaining health and warding off disease. When we have to contend with accumulated filth or with contagious diseases, disinfection is necessary.

For simple cleansing a solution of one ounce of common soda in twelve quarts of hot soapsuds is sufficient. If a stronger and more efficient cleansing solution is required a half pound of common soda in three gallons of hot water will serve and also be feebly disinfectant. When it is necessary to prevent the spread of contagious diseases or to stop putrefaction, we have to use positive disinfectants. Boiling or steaming in closed vessels for one-half hour will absolutely destroy all disease germs. Furthermore, we may use any of the chemical disinfectants which we have before described.—*Medical Times.*

SALVARSAN IN ATHEROMA OF THE RETINAL VESSELS.—Dr. J. A. Patterson reported the case of a man 46 years of age who had syphilitic infection twelve years ago, and which he claims was treated for a prolonged period in an Eastern city. He came West in such poor physical condition that his physician had been trying for two months by rest, diet and tonics to get him in condition for the administration of salvarsan. The patient suffers from gastric crises, absent patellar reflexes and distinct Romberg



symptoms. The pupils are slightly larger than normal, react sluggishly to light stimulus but promptly on convergence. The patient's mind seems sluggish and he looks ill. Vision minus 5-20. In taking the field by Bjerrum's method, a lateral nystagmus was noticed which could not subsequently be elicited by rotation. No central scotoma could be found though he co-operated too poorly to make this certain. The color fields were reversed, but the form field was not contracted.

Ophthalmoscopically the right nerve was pale, particularly the temporal edge, and above and below the nerve there was an area of pale reflex as if there had been an exudation. There is an area to the nasal side of the disc giving a peculiar reflex as if the retina was wrinkled, there probably having been an edema at that point. The retinal vessels have thickened coats and where the veins and arteries cross above and in from the disc there is an area of thick exudation. In the left eye the upper retinal vein just above the disc is occluded by the artery which crosses it. The small macular vessels running horizontally on the disc have markedly thickened coats. July 27, the patient was given a full dose of salvarsan intravenously. The patient was not seen again until Aug. 7, when the improvement in his general condition was very marked, the thickening of the retinal vessels greatly lessened and some areas of thickening previously seen could not be found. O. D. vision 5-12; O. S. vision 5-9. The patient being 46 the salvarsan was given with some hesitancy, fearing that the patient had gone beyond the stage where it would be of any value. The patient has not been seen since the last mentioned date. His family physician tells me he gave him another dose of salvarsan on September 11, at which time gastric crises had ceased and his condition was much improved. The first dose was 0.40 and the second dose was 0.45 mg.—*Annals of Ophthalmol.*

WILLIAM SPENCER, M. D

FAILURE OF VISION OF OBSCURE ORIGIN—PERHAPS GLAUCOMA SIMPLEX.—The case was that of a man aged 76, who gave a history of inability to see distinctly, and of dull frontal headache after near work. He sees four artificial lights where there is only one, and a ring of light passing through all four, but of the same color as the lights, without rainbow tints. Vision began to fail a year ago. He has been wearing a plus 4.50 sph. before each eye for all near work. Distant vision is 15-20 minus with plus 2.00 sph. Repeated tests have failed to show increased tension. The pupils and anterior segments are normal. The lenses are sclerosed and hazy, with fine punctate opacities, chiefly in the anterior capsule, and two narrow spicules in the inferior cortex. The discs are paler than normal, with a slight bending of the vessels over their edges. Several of the retinal vessels are markedly tortuous. In near vision there is exophoria of 15 degrees and right hyperphoria of 1 degree. The fields of vision, especially the left, show very marked concentric contraction. Knee jerks normal. Urine negative. Blood pressure 150 mm. As regards diagnosis, glaucoma simplex or optic nerve atrophy is suggested.—*Dr. F. R. Spencer, Annals of Ophthalmol.*

WILLIAM SPENCER, M. D

**BACKACHE IN WOMEN.**—Backache occurs in women even without genital affections twice as often as in men, according to Theilhaber. He has found it in 20 per cent. of women. The same number had formerly had this symptom for some weeks or months. With normal organs backache is found (a) occasionally at normal menstruation; (b) with retention of blood clots; (c) also with transient collection of fluid blood; (d) with spasm of the circular muscles of the os uteri. There is also a nervous backache. The author does not believe that most backaches are due to traumatism of the sacro-iliac articulation; neither does he believe that the displacement of the center of gravity forward is a frequent cause. Backache is often of rheumatic origin. A frequent cause is spastic obstipation, and also coccygodynia. Of conditions not associated with genital anomalies may be mentioned the backache of pyelitis, gout of the kidney, renal calculi, sigmoiditis, intestinal carcinoma, strangulated hernia, hemorrhoids, enteroptosis, spinal diseases, spinal caries and tumors, injuries of the pelvis and spine, sacralgia, the backache of gastric ulcer and cancer, gall stones and hepatic cancer; occasionally backache is caused by great muscular exertion. Backache may also be caused by unsatisfied sexual excitement, and from precipitate ejaculation on the part of the male. Excesses in venere and onanism may also cause the symptom. Among the genital anomalies in point of frequency is carcinoma. Of uterine myomata the submucous form, which cause uterine colic, stand first. Ovarian cysts most frequently cause backache when associated with torsion of the pedicle. The pain may also be caused by pelvic peritonitis, salpingitis in its various forms and tubal pregnancy. Retroflexion of the uterus, to which this symptom is so often ascribed, is usually not the cause. In incarceration of the retroverted uterus which is usually found in the beginning of the fourth month of pregnancy, severe backache is often found. The same is also true in prolapse of the uterus and of the vagina.—*Zentralbl. f. Gyn.* 1911, 1559.

THEODORE J. GRAMM, M. D.

**AUTOGENOUS PUERPERAL INFECTION.**—In some studies relating to puerperal infection Pankow (Freiburg) has encountered some interesting facts. From his examination of the bacterial flora of the vulva, of the introitus and of the vagina, he concludes that bacteria ascend from the vulva, but through the agency of the protective forces of the vagina they are usually rapidly destroyed. This self cleansing of the vagina the author demonstrated in two cases, and concludes that in spontaneous infection with endogenous microorganisms those from the vulva are the ones concerned. These induce fever if, as when the labor has been prolonged after rupture of the membranes and the soft parts have been crushed and lacerated, more favorable conditions for germ growth are produced, which lead to an increased development of their virulence and powers of invasion, as clinical experience has shown.

In order to determine what may be accomplished by disinfection in reducing the frequency of endogenous infection, the method of disinfection was varied in two series of cases. In 803 cases of spontaneous deliveries the external parts were shaved and disinfected, and in these cases the morbidity was 12 per cent. In 2,610 cases the patients were

douched and not disinfected and the morbidity amounted to 6.7 per cent. In 397 cases of operative delivery which were shaved and disinfected the morbidity was 17.8 per cent. Cases douched and not disinfected, 117 in number, had a morbidity of 14 per cent. From these results the author thinks we may conclude that we are not able by disinfection to reduce the frequency of spontaneous infection by endogenous germs. It even appears as though from excessive efforts at disinfection it is possible to cause harm rather than good. This suggests the thought that just as the non-pathogenic bacteria of the vagina and of the skin are not to be regarded as indifferent or even harmful saprophytes, but just like those of the mouth, of the intestinal tract and of the vagina, it is likely that they have a certain function by their presence to prevent the development of pathogenic bacteria and to limit their virulence.—*Zentralbl. f. Gyn.* 1911-1555.

THEODORE J. GRAMM, M. D.

CARCINOMA OF THE VULVA.—Machenhauer says that at a recent meeting of a medical society only one physician could be found who had actually seen a healed case of this sort. And yet the results are not so bad as this would seem to indicate, for Goldschmidt found 10 per cent. healed among 213 cases; and Schultz found 14 cases free from recurrence five years after operation, and 12 others free after three years.

The author then reports the case of a woman, 66 years old, who had a cancerous ulcer on the labium existing for three months, diagnosed by microscopic examination. There was no recurrence five years after operation.

The second case concerned a 67-year-old woman having a similar condition, but with enlargement of the inguinal glands, which were also removed at the operation. In this case three years have elapsed without recurrence after operation. Since recurrence is usually quite early it is probably safe to speak of a definite cure in these cases. These cases also seem to confirm the experience that the older the patient the more benign is the carcinoma.—*Zentralbl. f. Gyn.* 1911-1541.

THEODORE J. GRAMM, M. D.

CHRONOLOGICAL RELATIONS OF OVULATION AND MENSTRUATION.—Busquet (*La Presse Medicale*) in considering the chronological relation of ovulation and menstruation, cites the observations of Leopold and Kufferath, who examined the ovaries of women operated on during menstruation, and during the intermenstrual period, with reference to the presence of the corpus luteum. They found that the menstruation occurred at the moment of maturity and rupture of the ovisac. Pouchet has published a case of unique coitus in which the act occurred fifteen days after menstruation and fecundation occurred. Fraenkel was of opinion that one of the results of the internal secretion of the corpus luteum was to cause menstruation. In nine cases of laparotomy with healthy ovaries he cauterized the corpus luteum and prevented the next menstruation. Villemain found that the cycle occurs thus: the Graafian follicle ruptures midway between the menstrual periods; twelve to fifteen days afterward the corpus luteum is present and menstruation occurs. Conclusions are that men-



struation is a hemorrhage caused by the corpus luteum fourteen to fifteen days after ovulation. This question could be decided if surgeons would systematically examine the follicles of all women on whom laparotomy is done, in connection with the date of the last menstruation.—*Charlotte Med. Journal*.

**CAMPBOR IN GYNECOLOGICAL PRACTICE.**—Roger says that in the East camphor, native in Formosa, is extensively used for the purpose of relieving pain and as a disinfectant, though it is also used as an internal remedy. In Europe its use is mainly restricted to heart stimulation, though among the people it is added to cataplasms and in the form of camphorated oil. Occasionally it is used to stimulate granulations in surgical practice. When combined with irritants it tends to modify their destructive action upon the tissues. Thus, if combined with carbolic acid and alcohol the action upon a wound is not destructive but rather disinfectant and it removes irritation. In popular practice camphorated oil has been seen without other antiseptics, to greatly diminish suppuration. In burns it relieves pain, and is useful where the wound cannot be kept clean.

The author has long successfully used camphor in parametritis, perimetritis, salpingitis, and inflammatory processes in the pelvis where ichthylol tampons have been ineffective. Glycerine was used as a vehicle. Pain is quickly relieved. In pelvic cellulitis it seems to hasten and localize the abscess. A high percentage of camphor is not required—a  $2\frac{1}{2}$  per cent. solution being recommended. To this solution the author likes to add 10 per cent. boric acid, and in gonorrhœal processes 2 per cent. alumnol.—*Zentralbl. f. Gyn.* 1911-1313.

THEODORE J. GRAMM M. D.

**GYNECOLOGICAL LESIONS IN RELATION TO SUICIDE.**—Bossi (Genoa) thinks that both gynecologists and psychiatrists have been too indifferent in regard to these cases. In the experience of the author at least one-half of all cases of suicidal mania are referable to lesions in the genital sphere and arise either during genital development or in association with delayed development or at menstrual crises; that is just before, during or after menstruation; during pregnancy, the puerperium and the menopause. These are not the direct causes of suicidal mania, but they have a certain etiological influence, supported by the gynecological lesions. The condition is also found in association with uterine diseases, and sometimes the lesions are relatively slight. The severer forms, such as inoperable cancer where the patient knows there is no hope for her; also tumors, adnexal diseases with much pain are not those with which this mania is so often observed. The tendency is rather seen in infectious chronic metritis, particularly with deviations of the uterus. The most frequent lesions encountered are those of flexions with infections from which a certain amount of autointoxication exists. Suicidal tendency is also seen at the time of the menstrual period. In women having infectious endometritis the congestion is increased at this time, as is also the absorption of toxins. Anteflexion with defective development is also met with in these cases. The author relates a number of instances in which operation entirely cured the patients.—*Zentralbl. f. Gyn.* 1911-1265.

THEODORE J. GRAMM M. D.

## Monthly Retrospect

### OF HOMOEOPATHIC MATERIA MEDICA AND THERAPEUTICS

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CONDUCTED BY A. LEIGHT MONROE,

Miami, Florida.

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REMEDIES FOR CONVULSIONS IN CHILDREN.—Our Materia Medica is rich in true and tried remedies for convulsions in children. Let us turn our attention first of all to the most important or most frequently indicated remedies in this complaint. They are *artimesia vulgaris*, *belladonna*, *cina*, *helleborus niger*, *opium*, *stramonium*, *veratrum album* and *zincum*.

Care must be taken in all cases to remove the cause first. If it results from an impaction of the bowels see that the bowels are clear first. Careful attention must be given to the manner in which the child is clothed and fed, as well as its constitutional tendency to disease.

*Artimesia vulgaris* is a remedy that has convulsions resulting from irritation caused by worms; this is also true of *cina* and *stannum*. The peculiar feature about *artimesia* is that convulsions are in rapid succession for a short time; then there is a long interval before another succession of convulsions appear. You will also remember that the child having convulsions calling for *artimesia* has a peculiarly offensive sweat, the odor of which is not only fetid, but is very similar to the odor of garlic. Then, again, the convulsions calling for this remedy are found most frequently in sucklings or teething children.

*Belladonna* has convulsions from cerebral involvement. Here we find constant starting from sleep with a wild and maniacal look the pupils are dilated, the head and hands are very hot and the eyes are red and staring with a flushed face. Spasms or convulsions are followed by sopor or deep sleep, the convulsions usually commence in one of the arms, then spreads over the body which is thrown backward and forward. During the interim of a convulsion the child is very drowsy, but cannot sleep; there is often sudden twitchings and jerking of the muscles, whether asleep or awake, and with this there is much screaming and crying, sometimes for hours without any perceptible cause.

*Cina*, like *artimesia*, has convulsions resulting from irritation caused by worms; this child is feeble, lax and always ailing; it is very fond of sweets and sweet things; there is a painful sensitiveness in the limbs and of the whole body to motion or touch; the attacks usually come on early in the morning or in the evening, and are most violent after eating. The child, during the convulsion, throws its arms from side to side; the extensor muscles become convulsed and the child suddenly becomes stiff, and this is followed by trembling of the whole body with blue lips and

whining. Before a convulsion, the child complains of pain in the throat, chest and in all the limbs; during the convulsion there is a clucking noise in the throat as if water were poured out of a pail from the throat down into the abdomen. The child is peevish, cross, cannot be pleased, is irritable, strikes those that are around it and is often taken with sudden attacks of fever; one or both cheeks become very red with marked paleness around the mouth.

*Helleborus niger* The real cause of convulsions calling for *helleborus* lies deeply in the brain centers and those centers controlling the renal track. Nursing children are often taken with these convulsions, during which the body is extremely cold, the urine is very dark with a sediment like coffee grounds; the child complains of an intense and intolerable pain in the head as if an electric shock passed through it. This pain in the head and electric shock-like sensation usually precedes a spasm.

Opium is especially indicated in convulsions resulting from fright or fear; the child wakes up apparently frightened, crying, screaming and finally the spasms set in; the child jerks from head to foot, throws its head back, the eyes are upturned, the mouth open, the chin quivers, legs and arms are spread out and after the paroxysm is over the child falls into a deep sleep. These are the characteristics and when they result from fright or anger or the approach of strangers, you will know exactly what to give to prevent recurrence of the spasm. Then, again, in spasms of new-born babes where there seems to be no symptom except screaming during the spasm you will think of opium.

*Stramonium*. This remedy is indicated in convulsions resulting from a sur-charged system with toxins from suppressed or recession of an exanthem or in case where the exanthem or eruption does not appear as it should. Now, the child seems to be afraid and sinks back from objects on first seeing them; the convulsions are episthotonic from bright dazzling objects, water or touch; the abdomen is puffed, body thrown backward and the spasms continually change their character. The child itself is better in the light, worse in a dark room; ordinarily it wants company, is fond of play, but cries out as if it were frightened as soon as it falls asleep.

*Veratrum album*. The convulsions of this remedy are usually associated with some digestive or intestinal disturbance. Children needing this remedy are usually very pale with a cold sweat on the forehead. Now the strange characteristic of the spasm is this, that it is either preceded or followed by a cough; ordinarily the child is nervous and trembles all over after sudden or violent emotion.

*Zincum*. This remedy is thought of in convulsions resulting from suppressed scarlatina, though we may need it in convulsions resulting from other causes. The child cries out during sleep and if awakened expresses great fear and rolls its head anxiously from side to side; there is marked twitching in the various muscles; the whole body of the child jerks during sleep and when the convulsion is impending; the child seems to be cross and irritable for days previous; its motions are all hurried; the abdomen is distended and there is more frequent urination than usual. This is a useful remedy in the pale child during teething who is subject to convulsions; in the weak child who does not seem to be strong enough to



bring out an eruption to the surface and those whose nerve centers are loaded with poisonous toxine. It is also to be thought of when old eruptions suddenly disappear and the child is thrown into convulsions.

These remedies seem to cover the ground of convulsions almost entirely, but we have other remedies very characteristic of certain convulsions that one needs in a busy practice.

These remedies are *aethusa*, *ambra grisea*, *apis*, *calcareae carbonica*, *camphor*, *chamomilla*, *cicuta*, *coffea*, *cuprum*, *gelsemium*, *hepar*, *hyoscyamus*, *ignatia*, *ippecac*, *lachesis*, *lycopodium*, *magnesia phosphoricum*, *nux vomica*, *silica* and *sulphur*.

The indications will be given as briefly as possible:

*Aethusa*. This remedy has spasms with stupor or delirium, the eyes are turned downward, the convulsions are epileptiform with clinched thumbs and red face, episthotonus, great weakness; children can neither stand nor hold their heads up.

*Ambra grisea* has convulsions which are largely reflex; they are characterized by a sensation of strangling with great difficulty in swallowing; the child is aggravated by warmth or getting warm and is relieved by being cool or cold; this is especially true in nervous children.

*Apis* is usually recognized by trembling and jerking of the limbs, loud shrieking, and boring the head into the pillow. Convulsions from brain affections with these symptoms cannot be mistaken.

*Calcareae carbonica* has primarily, scrofulous diathesis, open fontanelles, teething either too slow or too rapid and marked perspiration about the face and head.

*Camphor* has spasms from suppression of catarrh in the head or chest. It also has trismus and tetanus neonatorum originating in some wound. Of course this wound affects either the nervous or venous system.

*Chamomilla* has irritation, anger; the child stretches or bends itself backward, kicks, fights and screams, and during the convulsion the legs, one or the other or both, are moved up and down, grasping and reaching with the hands, mouth drawn from side to side, hot sweat about the head and face, eyes staring, jerking, twitching even in sleep. These convulsions often follow anger or emotions of the mother or wet nurse.

*Cicuta*. This is one of the first remedies to think of in convulsions brought on by injury. It is characterized by violent shocks to the head, arms and legs which causes the child to jerk them suddenly; it seems to be well and in great spirits when suddenly it becomes rigid, then relaxation sets in and is followed by great prostration; its spasms are renewed from the slightest touch or the least walking or talking.

*Coffea*. This is particularly useful in teething children who are very nervous and who grind their teeth at night after some over excitement, especially useful in weakly and excitable children.

*Cuprum* has spasms which begin in the fingers and toes. Now these spasms are often preceded by violent vomiting of phlegm with marked blueness of the face and mouth, and any attempt to swallow fluids causes a gurgling in the throat. After a convulsion the child screams, turns and twists until another spasm begins, particularly useful in spasms during dentition, whooping cough or retrocession of some inflammatory eruption.

*Gelsemium* has convulsions from reflex irritation; during the convul-

sion the face is a deep red and when the child can express itself it says its head feels very large.

*Hyoscyamus.* This is characterized by angular motions, that is to say, that there is sudden twitching and starting of the muscles in one part of the body and then in another. These twitchings and convulsions are usually worse after eating, during the convulsion there is loud shrieking, frothing at the mouth, the muscles seem to be agitated and this is followed by a profound sleep. The causes are usually fright, fear and worms.

*Ignatia.* The particular feature about the spasms of this remedy is that the spasms return at the same hour daily; generally occur at the commencement of eruptive fevers, during dentition with frothing at the mouth, kicking of the legs; after punishment of the child it screams and trembles violently all over and then has a spasm, or after fright or prolonged grief of the mother or nurse the child has a spasm. The spasms are usually preceded by very hasty drinking and, as a rule, the children are extremely timid and nervous.

*Ipecac.* This remedy has spasms resulting from over-indulgence in mixed food; there is much nausea and vomiting before or even during a spasm; the body is rigid, stretched out, followed by spasmodic jerking of the arms; it is often indicated in convulsions from suppressed eruptions.

*Lachesis.* This is a remedy to be thought of in convulsions which come on during sleep; there is trembling of the tongue, cold feet, the body is stretched backward with screaming.

*Lycopodium.* This is to be thought of in convulsions resulting from incarcerated flatus; the spasm is accompanied with screaming, foaming at the mouth, unconscious and throwing the arms about.

*Magnesia phosphorus.* This remedy is very similar in some respects to belladonna; the spasms come on early in the morning and it is also found especially useful during dentition, especially so if the child is very sensitive to every impression, even to touch and particularly to noises.

*Nux vomica.* The great remedy in convulsions resulting from indigestion, high living or bad temper of the mother or nurse. You will notice particularly that the convulsions are renewed by the slightest touch and followed by a deep sleep.

*Silica.* To be thought of in convulsions resulting from vaccination or convulsions returning at the change of the moon; the attacks are preceded by coldness of the left side, shaking and twisting of the left arm and perspiration of the scalp.

*Sulphur.* This is the sheet anchor in convulsions of scrofulous children, convulsions following suppressed eruptions and often needed to remove the underlying causes leading to these spasmodic outbreaks.

Now then, more particularly, let me call your attention to the great importance of *calcarea carbonica* and *chamomilla* in convulsions during dentition. It is true any remedy in the *Materia Medica* may be indicated by the totality of symptoms, but these two remedies seem to take precedence in the majority of cases.—*G. F. Dienst, The Critique.*

# THE HAHNEMANNIAN MONTHLY.

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JULY, 1912

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## A PLEA FOR THE OLD FASHIONED GENERAL PRACTITIONER.

BY

JOSEPH C. GUERNSEY, A. M., M. D., PHILADELPHIA.

(Read before the American Institute of Homœopathy, at Pittsburg, June 21, 1912.)

MOST of us remember that familiar family friend and warm-hearted worker who sought to substitute ease and peace for pain and suffering; that tender hearted sympathizer in sorrow and genial participator in happiness; that skillful prescriber in pestilence; that capable and comforting hand in binding broken bones—that most loved and lovable being whom Ian Maclaren depicted in “A Doctor of the Old School” as one of the sweetest and most needed, most welcomed and most enviable of characters ever vouchsafed by a Gracious God to the human race.

With patience inexhaustible and love undying; with interest unflagging and devotion unswerving; ready in daylight or darkness, in sunshine or storm, rested or weary, awake or asleep—at the call for “Help,” he responded as promptly and willingly to charity cases as to those who paid him. He heard the cry of suffering humanity and rushed to its relief without stopping to appraise its value in money or in fame.

We have all experienced the thrill of pride and pleasure on entering the house where a dearly loved one lay seriously sick, to hear whispered the welcome words, “The doctor has come!” No being in this world, since time began and space had birth, has been more loved and trusted, more respected and admired, more sought after and longed for than the Family



Doctor, i. e., the old fashioned General Practitioner. He deserved all the honor, all the praise and all the worship he received for there was nothing in the domain of the medicine of his day that was not his to dispense. To subdue sickness or staunch a bleeding wound; to bring a new life into the world or smooth the path of one departing, all help at such times was expected and received from the family doctor,—the general practitioner.

There are many, *very* many thousands of doctors who have devoted all their energies of head, heart and life, to their work as general practitioners and the human race has been infinitely improved mentally, morally and physically by their faithful and able ministrations. Multitudes of these general practitioners have seen forty to fifty years of active service and their experience, individually and collectively, is of untold value. Every one of them has officiated at the birth of hundreds of children and has often delivered the children of the children, he had assisted into the world many years before. For long periods of time these old family doctors have attended the same families, their children and grandchildren. The specialist comes comparatively seldom into the family and then only to a very limited degree. The general practitioner is with his families at all times and under all conditions; he learns their wants and how to supply them as he travels with them through life's journey. From this close and continuous association with succeeding generations he knows as intimately the individual history of parents and children as the stock-breeder knows the pedigree and individual characteristics of every colt and heifer that feeds in his fields. The human race would suffer a lamentable loss and irreparable injury if deprived of the experience of the general practitioner. There is no truer precept in the domain of knowledge than the two words "*Experimentia docet.*" The school of experience is proverbially expensive and to the specialist untrained by the all-embracing education of the general practitioner it is doubly so. The experience of the general practitioner in medical lore is hard earned and dearly bought but it is priceless in value. It is the general practitioner—the ideal physician—who recognizes, "Disease as an enemy that never retreats, that never surrenders, that gives no quarter; over which there is no victory—save absolute annihilation." He realizes that every patient is a special study; that every symptom must be ascertained.

traced to its origin and weighed as to its meaning; that every prescription is a drill in analytical therapeutics. The general and particular knowledge of diseases with their ramifications throughout the human system and practical experience in their treatment, can be obtained only by the physician who in general practice has earnestly and honorably combated and conquered morbid forces in all their forms and varieties.

By slow but steady decline, however, the general practitioner seems to be disappearing from his life's labor and love. \* "A recent canvass of 13,800 physicians showed that nearly 5,000 of these devote themselves to distinct specialties. . . .

"Statistics show a positive and steady decrease of the proportion of general practitioners to specialists. In 1906, specialists were as 3.37 to each thousand of the population; in 1911, they had increased to 6.13 in each thousand of population. On the other hand, the non-specialists show a decrease during these years." Many of the above began as general practitioners but later became specialists.

I plead for the return and retention of the general practitioner, because he fills a place that *no one* else can fill. He must not be allowed to go because he cannot be spared. He is needed to-day as much as he ever was—as much indeed as the watch needs its balance wheel and the mariner his steering rudder. In addition to his medical services, as a conservator of health and promoter of longevity, he is needed as a family friend—as a confidential adviser on the important matters of marriage and birth and all other subjects relating to family welfare. A most progressive prophylactic of the present day against diseased and feeble minded children has been adopted by Dean Walter T. Sumner of Chicago by his announcement that no marriages will be performed at the Cathedral of SS. Peter and Paul without certificates of health, signed by reputable physicians, that applicants for marriage are normal physically and mentally and have neither an incurable nor communicable disease. In Dean Sumner's estimation, † "this is the plain duty of the Church—not only to the present generation *but to innocent children to come*. This step was taken . . . that there shall not be . . . blinded eyes of little babies twisted limbs of deformed children, physical rot and mental decay." The general practitioner is the only one capable of

\**The Sun* (New York) March 2, 1912.

†*The Survey*, May 18, 1912.

bestowing this certificate of merit and why in the interest of humanity should it not be required? Why should not the same care be taken in the production of children as is taken by stock breeders in the progeny of standard stallions and matchless mares? For money reasons only, because it does not pay in dollars and cents, stockmen do not breed to inferior material. Why should not infinitely more care be taken in the production of children whose healthy and happy existence on earth is of such untellable value?

We particularly need the general practitioner in the preparation for specialism in medicine because no physician can become a competent specialist, much less rise to the highest degree of specialism, unless he has been grounded *in* his specialty and trained *for* his specialty by at least five to ten years of full experience in the same general practice as that of the old-time family doctor. The specialist needs a broad and general knowledge of the whole domain of medicine; only so can he escape the terrible blunders resulting from narrowness of training or experience. Specialism based on efficiency is to be commended and nothing can be said against the specialist who has acquired the qualifications essential for the work he does. Within recent years, however, there has been an enormous increase of *premature specialism*. Medical graduates fresh from college, after spending a few months in various clinics abroad or having taken one or two courses of a few weeks in a post graduate school, set themselves up in practice as competent surgeons and specialists. The result is what inefficiency always produces. \* "Every capable surgeon well knows the harm done by premature surgeons—men who have no more moral right to practice major surgery than a carpenter. The day is coming, and God speed it, when no one will be allowed to perform a major operation until he has qualified as a surgeon; . . . sooner or later the state must step in and insist that the surgeon shows that he is amply qualified before it . . . gives him *entré* to the human abdomen. Likewise the specialist will be required to measure up to special standards, *not only of knowledge but of efficiency*." A supreme test of a surgeon's efficiency would be the reporting of his mortality in proportion to his operations and for the specialist to report his proportion of failures. This conclusive test—unpopular though it might be to

\*Editorial in *American Medicine*, December, 1911.



many surgeons and specialists, would surely be of vast benefit to the public.

Complete qualification for specialism comes and can come only by a rigorous training as a general practitioner. We do not, to-day, need any higher entrance requirements to a medical college than now exist. What we do need, what we should demand and insist upon is an additional year to the medical curriculum to be spent in practical work in hospital service or with a physician in the general practice of medicine.

As stated above, the general practitioner seems to be passing away and his demise is being accomplished by the fact that from an active practitioner, he is rapidly becoming a mere distributor of cases to the specialist.

*Why* is he a distributor? In response, it must be frankly acknowledged that while "Specialties" in medicine are at the present day being rapidly developed, the work of the general practitioner, in the words of a recent writer, "is so far in the rear as to create some doubt whether he belongs to the procession or only happens to be traveling that way." It is true the general practitioner of yesterday does not fill the requirements of to-day and much less can he do so for to-morrow. If he would regain and retain his usefulness and power in medicine and share in the conquests of the specialist, he must place himself *en rapport* with the progressive and scientific medicine of to-day. He must know things and do things which a few years ago were largely unknown and undone. Especially must he bring himself up to the modern methods of diagnosis. If he does not analyze urine chemically and examine it microscopically, he should know what abnormal conditions are indicated when an examination is made for him. He need not take an X-ray or make a blood count, but an X-ray being shown him he should comprehend the lesion it demonstrates and a blood count being estimated he should understand its significance and appreciate its value. If he can not use the cystoscope nor analyze the stomach content nor feces, such work being reported to him, he must be qualified to recognize and utilize the pathological information exhibited by the findings. He also requires a working familiarity with minor and emergency surgery. He may not remove an appendix but he should be able to diagnose appendicitis by its clinical history even if McBurney's point be but slightly responsive. He is not expected to operate a mastoid abscess but he ought to declare such a condition from the

symptoms. He must also examine and ascertain correctly the condition of the ear drum and remove impacted wax with the syringe or forceps. He is not obliged to prescribe eyeglasses for defective vision but he needs enough practical knowledge of the ophthalmoscope for diagnostic purposes and enough of optometry to use the ordinary test cards, etc. Though many physicians may not know it, questions upon the eye and ear, involving knowledge hitherto supposed to be in possession of the specialist only are now included in the questions of State Medical Examining Boards. These are only a few of the modern methods of dealing with medical problems; many more are distinctively obvious. Those lacking in these essentials must make good their deficiencies before admittance to the ranks of the medical men of to-day.

There is a universal complaint among general practitioners, of all schools of medicine, that their work has very largely fallen off. There are two reasons why this lament is true. One is the common excuse that the profession is overcrowded—that there are too many doctors ready to respond to “calls”: the other and the chief reason is, the general practitioner is not so well qualified to-day as formerly, to meet the exigencies of his profession. Years ago doctors graduated as “physicians, obstetricians and surgeons,” scattered through the country and, measuring up to the requirements of their day, *they made good!* They healed the sick, delivered women, reduced dislocations, set fractures, staunched bleeding wounds and sent for an “expert” only when it was really necessary. Now-a-days they depend upon specialists to do such work for them. No wonder the practice of the general practitioner has decreased—on his part it is almost a case of “Mene, Mene, Tekel Upharsin.” The general practitioner should return to his birthright and do this work himself as did his predecessors and then shall be heard the gladsome strains of “The King has come into his own again”!

Is this demand, that the general practitioner be versed in the learning of the present day, excessive? I do not think so. It would, have been excessive thirty or even twenty years ago when all applicants were freely admitted to medical colleges irrespective of mental calibre or preliminary education. To-day things are different. To-day men of limited mentality and deficient preliminary education are debarred from medical colleges. To-day matriculants are so well trained mentally

that the medical qualifications demanded of them are perfectly reasonable because wholly within their grasp and power. By weeding out inferior material, viz., the rejection of men of too limited mental powers and those deficient in preliminary education, we now have men of strong minds amply trained by "q. s." education, in the high school and college. As a matter of fact, it is far easier for the trained college or high school graduate to learn thoroughly the increased medical requirements of to-day than it was twenty years ago for the untrained and uneducated mind to acquire even crudely, the limited medical requirements of that day. Everything to-day makes for the betterment of the general practitioner because of the vastly improved educational facilities in medical colleges. There are better professors and better teachers; there is more abundant clinical supply—surgical and obstetrical for practical purposes and medical material for diagnosis and treatment; individual teaching and drilling in the use of the ophthalmoscope, stethoscope, cystoscope and microscope, the pelvimeter, the sphygmograph—in short, all branches and departments of medical education are now most comprehensive in scope and instructive in character. The general practitioner of to-day has "double lined and copper riveted" advantages over the family doctor not only of ye olden but of comparatively recent days. Old-time doctors had no swiftly flying automobiles to waft them from distance to distance. Their patient plugs jogged soberly along level roads and crept slowly up hills—the very hills which are to-day climbed at a faster gait than is attained on level ground. In former days a patient ten, or even five, miles away was a matter of deep consideration to the tired or to the overworked doctor whose "calls" lay in every direction; to-day the automobile annihilates time, space and high hills. They had no office telephone with which, luxuriously lounging in an easy chair, to call the trained nurse and ask, "How is the patient? What are the pulse, temperature and respiration?" On the contrary, it was their duty to go early in the morning and late at night, in the heat or cold, sunshine or storm and ascertain in person the condition of a dangerously sick patient. A recent writer compares the telephone to a long stethoscope with which the physician keeps in touch with the needs of his patient; he also says it has become as necessary a part of the doctor's equipment as any other medical or surgical tool. Aided by his trained nurse, his automobile, his telephone, his typewriter and



numerous other time-saving and labor-saving conveniences of to-day he has far more time to study and keep up with the progress of medicine than they had. Added to all this are the post-graduate courses, offered by the best medical colleges in the country, standing wide open, to which any and every practitioner can repair at but small expense and little loss of time. At these courses he can "brush up" his rusty remembrance of early learning and have *practical* teaching in all that is newest and best in medicine. There is no doubt at all that these marvelous adjuncts were added to medicine for the purpose of increasing medical knowledge and medical efficiency. I repeat, it is *not* too much to ask the general practitioner to march in the front ranks of his profession instead of loitering in the rear, knowing no more of medicine than did those of former years with their limited advantages and hampered opportunities. Some recent writers assume that owing to the rapid spread of preventive medicine the general practitioner will ultimately be relegated to a very secondary place—if not wholly dispensed with—because sickness being "prevented" there will be none to "cure."

Whether medical conditions will ever so exist as to abolish the "curing" doctor is a contingency too remote for any present profitable discussion. It surely *is* a safe proposition for the general practitioner of to-day to prepare himself for the amount of remunerative work that will come to him if he be competent to perform it.

Another potent reason why the general practitioner of to-day must be better educated in the science of medicine is, *the public demands it*—not only "demands" but positively WILL HAVE IT. Daily newspapers, monthly magazines and popular lectures have in late years disseminated a vast amount of medical knowledge among the laity. This has been so largely absorbed by the public that the public is now sufficiently educated in medical matters to realize and appreciate the degree of knowledge and efficiency a general practitioner has attained. The physician cannot to-day stand aloof and disdainfully decline to discuss a medical situation with a layman because the latter knows entirely too much to be arbitrarily set aside or contemptuously ignored. To-day it requires a well posted medical man to acceptably argue medical topics with the lay readers of medical literature and it is a fact that large numbers of intelligent people read medicine from pure love of the subject. Thank God,

the public is being educated in medical matters! The public needs education in medical matters fully as much as does the medical profession. If the public had been sufficiently educated in medical matters years ago, the Greeks would have had no oracle at Delphi nor would we endure Osteopaths, Vitapaths, Eddyists, and other fads and fancies which have brought the Divine Science of healing into contempt and have cost much needless suffering among the sick, followed often by death depriving families of comfort and support. Almost all such suffering comes from ignorance. Educate the public in medical matters and quackery and medical intolerance will be annihilated forever. Every successful movement for human welfare in promoting health and longevity has been animated, advocated and ultimated by the medical profession and often in the face of bitter opposition from people who were to be benefited. Educate the people and they will act in harmony with us instead of in opposition.

Dr. Abraham Jacobi, in a recent \* address delivered in Boston, spoke these words: "What I want you to learn is to revere and adore the general practitioner. There are a few left of the species called family physician. Mind what I say: In twenty-five years he will recover the place of honor which was his fifty years ago. . . . He will again be the general adviser, having learned from the laboratory men and the specialists who are the modern handmaids of practical medicine; knowing the history of his trusting friends and taking an interest in their wholeness and wholesomeness,—the chum of the old people, the intimate of confiding girlhood and the uncle and oracle of the kids."

Dr. Jacobi says the old-time Family Physician will "come back!" Doubtless he will "come back" but it will be only when he has mastered modern medicine. He who does this will strengthen his standing in the profession; will add to the respect in which he is held by the public and, what is most important, will retain in the service of suffering humanity that indispensable adjunct to medicine, THE GENERAL PRACTITIONER.

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\*"Significance of the General Practitioner," *Boston Med. and Surg. Journal*, March 21, 1912.

**A KNOWLEDGE OF HOMŒOPATHIC MATERIA MEDICA NECESSARY TO  
THE INTELLIGENT PRACTICE OF MEDICINE.**

BY

ELDRIDGE C. PRICE, M. D., BALTIMORE, MD.

(Read before the American Institute of Homœopathy, Pittsburgh, Pa.)

"WHEN one has to do with an art the end of which is the saving of human life, any neglect to make oneself thoroughly master of it is a crime."—*Hahnemann*.

What is "the intelligent practice of medicine"?

The answer to this question depends largely upon the age in which one lives, and also the given point of view of that particular age. In pre-Hahnemannian days intelligent prescribing included the Theriaca Andromachi and toxic doses of drugs generally, to say nothing of such mechanical means as copious bleeding, the moxa, etc., etc.

Jumping over the intervening century we find rational therapeutics interpreted very differently. An entirely new view of etiology prevails, and from the massive doses of dangerous drugs little or no medication is practiced.

Such is the attitude of the dominant school of surgical-medicine to-day, but not that of the practical school of homœopathy, and because of so large a class of physicians assuming this negative attitude towards drugs it is quite in point to inquire into the rational grounds for such a position.

It is a fact that many disease conditions disappear spontaneously and that the average surgical case will recover without medication, but it is also true that there is a class of conditions including both clearly defined medical cases and what may be termed surgical sequelæ, which always tend to dissolution. In this field, therefore, it is necessary to call upon all the resources within the scope of materia medica which may offer any promise of restorative aid; and at this point the physician is confronted by the necessity for decision as to the means which offer reasonable hope for palliation or cure of the patient.

One of the most difficult questions which confronts the medical profession is the establishment of the line between cases which are definitely curable and those which are definitely incurable. So many factors are involved in this prob-



lem that we are compelled to recognize the fact that the border land between the two classes of conditions furnishes the physician with material for his greatest successes as well as his greatest failures. Here we find cases amenable to modern methods of treatment which would have died under the methods of thirty years ago, and here we find cases that without doubt could be cured did we know a little more of etiology, of pathology, and finally of therapeutics.

Because of this last discouraging situation, the great majority of the medical profession come to the conclusion that as they do not know enough to cure with the means at command it is useless to endeavor to know more of these means, and forthwith "throw physic to the dogs," adopting the "expectant method," applying allopathic measures or antipathic measures from time to time as exigencies arise, without even knowing anything technically about these methods and even less suspecting the possibility of rescue from a difficult situation by a knowledge of homœopathy. No wonder surgery dominates medicine; surgery with its remarkable advances and equally remarkable cures. In this masterful ignorance of materia medica not only do physicians blindly draw assistance from antipathy and from allopathy, but in equally blissful ignorance do they lay homœopathy under contribution. This applies to physicians of all schools, but especially is it exemplified in the older school and in the homœopathic school; the difference in most instances being that the former does not know he is practicing homœopathy and the latter often does.

If the practice of the average physician of each school could be followed closely, it would be found that cures follow the application of all kinds of methods. This means, either, that the normal recuperative power of the average organism will in some instances restore the patient to health regardless of the treatment used, or that it may be possible to bring about cures through more methods or principles than one. In other words, it is reasonable to believe that cures sometimes result from the use of antipathic measures, from allopathic measures, and from homœopathic measures, respectively. It would, therefore, seem to be fallacious to assume that there is no method but the homœopathic that will cure, or that all cures result but from homœopathy, and that all other methods than the homœopathic method are harmful.

This may sound like heresy, but I believe it to be fact. However, because cures may result from other methods than the homœopathic, does not mean that in its legitimate field more cures will not result from homœopathy than from any or all other methods. For this reason it would seem to logically follow that the best results in the practice of medicine may be secured by the men who not only believe in but who practically apply homœopathy; and further, superlatively good results may be expected in the practice of him who not only applies homœopathy, but who applies it intelligently. For such results it is not enough that the physician follow blindly the dictum of a textbook, however certain it may be that the author has drawn his views from homœopathic sources; but it is necessary that the prescriber understand, besides the etiology of the condition, the physiology of the organism or part of the organism involved, and the pathology existing, but that he understand both the method and the individual agent indicated under that particular method.

It is such thorough knowledge that gives the physician the ability to practice medicine intelligently, but it is just such thorough knowledge that is *not* possessed by the average medical practitioner. He may be a thorough anatomist, a good physiologist, a well-trained pathologist, a skilful surgeon, an expert mechano- and electro-therapeutist, but with all these attainments he may be a poor prescriber of drugs.

This applies to the members of all schools of medicine, but less to practitioners of homœopathy than to any other. The reason for this is not a matter of chance, but because of a central fact upon which rests the best therapeutic results of the practitioner of homœopathy; and that central fact is the knowledge of a definite principle upon which drugs act.

The dominant school of to-day not only ignores law or principle as a foundation for drug prescribing, but many go further and in some instances even deny that disease is beneficially influenced by drugs, or that drugs may be used effectively to aid in restoring health to the patient in post-surgical states. Herein, therefore, do we find the weak point in the equipment of the old school practitioner. But, it may be objected, the scientific physician as a matter of fact does recognize the curative power of toxins, anti-toxins and sera of various kinds, and surely these agents may be regarded as drugs—or the equivalent of drugs—and he even goes further

and offers explanations for the *modus operandi* of these substances.

All of this is true, but it is equally true that it renders the position of the therapeutic nihilist who accepts such facts and theories, all the more illogical when he refuses to use or to investigate the alleged uses of so many drugs from which the homœopathic practitioner daily derives positive curative results. The treatment of a case of persistent recurrent hæmorrhage from the nose, following enucleation of an eye by an eminent old school practitioner, to which my attention was recently called, is simply typical of much of the after treatment of the modern surgeon. The advice was: Do nothing, it will gradually cease.

We of the homœopathic faith, through observation and experience, are convinced that typhoid fever may be much mollified by the use of drugs; we also have cause to have faith in the homœopathically indicated drug in pneumonia, and even rheumatic fever has, in our experience, been much modified in intensity and shortened in duration by drugs with which we are all familiar. Because of ignorance of pathogenetic drug effects, and possibly the lack of patience to make careful investigation into the really scientific therapeutic indications for drugs, we find a large section of the dominant school accepting the conclusion that "typhoid fever is not a disease to be treated by medicines," that "pneumonia is a self-limited disease, and runs its course uninfluenced in any way by medicine," and that of rheumatic fever, "medicines have little or no control over the duration or course of the disease, which, like other self-limited affections practically takes its own time to disappear."

How is it possible that such statements are seriously made by grown men, whose opportunities for observation and experience have been all that could be desired, and whose minds are supposed to be unbiased by unscientific prejudices, how is it possible that such statements are not only seriously made but as seriously accepted by men of intelligence, when it is only needed to put to the test in a fair manner the claims made by thousands of believers in the law of similars, that disease may not only be modified but in many instances actually cured by drugs?

The obstacle to the acceptance of such therapeutic facts seems to be due to prejudice partly hereditary and partly ac-



quired. In the minds of some the word "homœopathy" seems to so irredeemably damn that to which it is applied, that in this corner of the field of science all investigation is suspended. If homœopathy as homœopathy could be driven from the face of the earth, and the law of similars presented by some modern savant of laboratory fame under a new name, then there might be some hope that the dominant school would accept drugs at a true therapeutic valuation. The recognition of virtue in infinitesimal amounts of the various sera now daily used is a step in the right direction, and in time we may expect to find the proscribed drug covered by this aegis of "substitution."

In the writings of some of our orthodox teachers we find evidences of a tendency to assimilate what they consider the practical part of homœopathy, but, of course, without crediting homœopathy with the material assimilated. This assimilating process is shown to be altogether crude and with all basic principle carefully eliminated. For example, belladonna and also calcicum sulphide are recommended in abscess; terebinth and cantharis in albuminuria; arnica, belladonna and baptisia in typhoid fever; aconite and pulsatilla in amenorrhœa; ignatia in hysterical aphonia; aconite and tartar emetic in bronchitis; cimicifuga in chorea; belladonna, pulsatilla and euphrasia in conjunctivitis; cantharis in cystitis; aconite, bryonia, phosphorus, tartar emetic and veratrum viride in pneumonia; podophyllum, arsenicum album, chamomilla and veratrum album in diarrhœa; aconite, belladonna and rhus tox. in erysipelas; pulsatilla in leucorrhœa; aconite and bryonia in pleuritis; aconite and cimicifuga in lumbago; aconite and pulsatilla in measles; phytolacca in mastitis; ipecacuanha in nausea; dros-  
era in pertussis, etc., etc., etc.

Practice of this kind may be regarded by some as liberal, but the absence of principle by which it is characterized debars it from scientific standing, and does not place its advocates high in the scale of intelligent practitioners of medicine.

It is this hit or miss habit of prescribing that has laid the foundation for therapeutic unbelief, and which is accountable for the two great classes of unscientific therapists in the older school; the one class that would obliterate and the other that would assimilate. Both these classes are more or less therapeutic agnostics, and the spirit of existence of both is unworthy of minds of "scientific mould." One prescribes in a

haphazard way and the other hesitates to prescribe at all because of the unsatisfactory state of knowledge of materia medica of the school concerned.

From our view point, therefore, it would seem that there are no rational grounds for such therapeutic agnosticism. Furthermore, from the overwhelming number of facts existing which show the positive curative power of drugs when used homœopathically, it would seem that ignoring the wisdom of becoming familiar with the homœopathic materia medica is irrational and inconsistent with the professions of men who are supposed to belong to the world of science.

Not only do many of the prominent men in the medical profession refuse to consider the demonstrable facts of homœopathy, but they would gladly see homœopathy and all that pertains to it in any and every phase forced out of existence. There are various ways for doing various things, and it is not impossible to evolve a situation in relation to homœopathy wherein there would no longer exist a class of people known as "homœopaths." In the kind of evolution meant the knowledge of materia medica which is necessary to the highest type of medical practitioner, would be possessed by all physicians. To accomplish this end it would be necessary to introduce instruction in practical homœopathy into every medical college in which it is not now taught.

Nothing would be more certain to extirpate what is now known as the homœopathic school. In that day all medical practitioners would be versed in the art of homœopathy, all medical practitioners would be practitioners of homœopathy, and the distinction "homœopathist" would no longer be a distinction, for the whole medical profession would acknowledge the law of similars, and the homœopathic school as a branch of the medical profession would have become merged into the trunk of the tree, from it would be derived the life of the tree, and it would be the tree. There would be no more homœopathic profession but a great medical profession without fossilizing and narrowing creed, a broad brotherhood of men all versed in a knowledge of the law of similars, all qualified to practice medicine intelligently, and all bent upon healing the sick *tuto, citu et jucunde*.

## SHALL THE MARRIAGE CANDIDATE FURNISH A CERTIFICATE OF GOOD HEALTH?

BY

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(Read before the Maryland State Homoeopathic Medical Society, May 1, 1912.)

SOME weeks ago a Chicago clergyman announced that after a certain date he would join in marriage only those persons who presented a certificate of good health signed by a reputable physician. That ultimatum was portentous. From men of deep thought all over the world similar expressions have come in recent years. This indicates a recognition of the fact that disastrous inheritance of disease conditions occurs widely. Following a recognition of the truth by men who are interested in the future welfare of their race, comes a demand for measures to remedy the dangerous condition involved.

Men of the medical profession see many instances of a bad physical inheritance. To us it is veritably a matter of our daily work. In our student days we were taught to make careful record of the "Family History" in our case records. All through the intervening years, as physicians, we have found the "Family History" an important feature of our case studies. After a little experience, none of us wonder why. In searching the family history we hunt for information concerning disease that may have been communicated to the patient from his forebears. And so often do we find it true, this tragic, damaging sequence, that we come to look upon it almost as an unavoidable, inevitable condition of life.

We have battled arduously against the cause of disease, but our efforts in the main are against extrinsic causes. Inherent conditions we regard as almost entirely beyond our control. Our care begins when the offspring is born, except what modern treatment does through care of the mother during life in utero. But the many influences prior to that time, the physical condition of his parents and their forebears, we have had no opportunity to regulate. That is past and done and the results must stand.

Now, however, comes the proposition, for the wellbeing of



future generations, to limit the progenitors of our race to people who are physically fit to produce healthy offspring. We doubt not the need for such control, nor that wondrous improvement would appear in a generation of progeny from healthy, selected parents. But even to those who have given this question the slightest thought, the circumstances arising from an attempt to regulate it by law loom so large and far-reaching, that it seems almost too great for human hands to undertake.

It is true, nevertheless, that this grave question, involving the physical welfare of future generations and the rights and privilege of those who would beget them, must soon be answered. Eventually, civilization will ask for a law to regulate it. A capable law may be evolved only from a basis of intelligent, truthful facts concerning this matter of disease inheritance. Hasty, prejudiced or unwarranted action will only bring hardship and injustice to innocent people, and make a bad matter worse instead of improving it. To regulate this matter in a way that will secure its one sincere object, the medical profession must perform a serious, arduous duty, for no matter who in the end will construct the necessary statute, our profession must supply the required data, the truthful record of facts upon which an effective law should be based, and recommend the salient features to be included in that law.

As a Society and as individual medical men, it is our duty to consider this matter our personal responsibility and at once inaugurate a systematic search for the truth. Many questions must be answered and details explained. The world will look to us for knowledge concerning them and if we are to perform this public duty we must closely study and record the data available to us daily.

Concerning the practical side of disease transmission from parent to offspring and succeeding generations, each one of us gains much experience. We see much of actual effects, no matter in what manner they occur. Theoretically, it is likely that disease is but rarely transmitted directly through inheritance. Actual transmission from parent to offspring requires that the particular germ of that disease enter into the substance of the spermatozoa or ovum. Transmission of the actual disease through the placental circulation or amniotic fluid is hardly more probable.

While up to a few years ago we believed in an actual in-

heritance of disease, we now consider instead that in most cases there is an inherited tendency or a lessened resistance toward a disease, transmitted to the offspring from an ancestor who was affected by that particular disease. Theoretically, we accept the distinction. Practically, however, the same bad results are possible now as always. The flaw is there; the unsound spot is in that offspring just the same. It may be possible to build up his resistance and overcome the tendency toward the disease of his parent. This favorable result is likely more possible than if he inherited the disease directly, but true it is that while some escape in this way, all too many develop the disease of their progenitors in spite of every effort to save them, and in infancy, youth, or promising adolescence, they succumb.

It is this practical end that concerns the public, and about which it must know. In countless instances we men of the medical profession begin a struggle for the survival of offspring from their very birth; we battle with them against their bad inheritance and in spite of every effort we see a big majority of them go down because of this grim spectre that is born within them, and which neither we nor they have power to control.

We have valuable measures to-day which we utilize for promoting health. People, too, are in sympathy with these measures and give them a good chance to effect results. In those not already doomed by a bad inheritance, much is accomplished by present day methods of treatment. Over and again, however, we are defeated by these inherited conditions. This brings us to consider whether we should continue to stand by in future, with our hands tied, and witness the awful sacrifice or whether we must put in force some more radical means and cut short the supply of damaged constitutions by striking at the fountain head itself and permit only those who are physically fit to enter into marriage and produce offspring.

The two diseases that do most toward producing unhealthy offspring are tuberculosis and syphilis. Often do we find a tubercular diathesis or congenital syphilis among our patients, nor are these unwelcome conditions by any means confined to the poorer classes. They are legion in hospital work, of course, but in private practice, we find many homes saddened because an idolized infant or a promising youth is thus marked by a bad inheritance and life cut short in spite of all effort to save him.

While the death rate from tuberculosis is in late years much reduced, even fifty per cent. in some regions, it is owing to a better knowledge of treatment and to limiting its spread through more effective isolation. The intelligent classes are learning the danger of inheritance in this disease and it is producing some effect in limiting its occurrence. But in spite of this better treatment working at a high efficiency, and a growing sentiment against the marriage of tubercular people, many thousands are dying annually from tuberculosis. It is not likely that treatment will ever reach a point in results equal to coping successfully with the supply. If such a dream should ever come true, it will be after many intervening years and after sacrificing a great army of human beings. The one promising move is to cut short the supply.

Inherited disease does not stop after damaging one succeeding generation. The second generation may suffer more than the first. In one family studied recently the maternal grandfather suffered from tuberculosis. A son developed the disease and the daughter showed no signs during life. But three of her children, out of four, were affected, one dying while the other two show a very apparent "tendency." They have the battle yet to fight, with this mark of Cain upon them as a constant source of menace. Incidentally, one of the latter will soon marry and is likely to transmit this fearful disease to her progeny. Thus, like casting a stone into a quiet pool, the ripple grows wider and wider.

In another instance the paternal grandfather died from what was termed "old-time consumption," a rather latent condition that permitted him among healthful surroundings and with little physical strain to live his three-score years and ten. But what he escaped, his children and grandchildren have suffered. Two of his children developed the disease when near middle life and died. Two of the offspring from one of these showed signs of tuberculosis early, and as young adults are now fighting to live. These instances are common to every physician. If evidence is needed we can pile facts upon facts until even the most skeptical is convinced.

Some men of experience claim that ninety-five per cent. of people at one time or another is affected by tuberculosis. Cut down these figures if you will, and still there is proof that a vast number are affected. Many overcome the disease because they have inherited no tendency, because their resistance is



good. The danger of infection is ever-present at the best. Those who have a tendency to the disease by inheritance or a lowered resistance, contract it easily and go to an early death. Stop the supply and the danger of spreading it will be lessened proportionately. Fewer people will possess this tendency, this lessened resistance. A body blow will have been struck at the disease and in time the world will be rid of it. Educating the public moderately concerning the facts has produced a sentiment that already has prevented many marriages among tubercular subjects. Educate the people more completely regarding the truth and take the results already accomplished as a criterion for handling the spread of other diseases. Cover the question then by a law that will control where voluntary action can not be depended upon, and at this menace surely a vital blow will be struck.

Syphilis is another great factor in producing unhealthy offspring. From the mucous membranes of the respiratory tract, straight through the organs and tissues of the body do we see this inherited taint. Diseased bone and various eruptions of the skin affect these unfortunate victims of a progenitor's misdeed.

Like tuberculosis, there is the added danger of contagion from those who are in the primary stage of the disease. This, of course, happens not so often, but one case we recall of a bride who contracted syphilis from her husband. Within one year of her marriage great ulcers developed in the pharynx. Much of the hard palate and the uvula were destroyed, and besides the physical suffering, she was doomed to go through life denied the power of articulate speech, making instead pathetic sounds that were as unintelligible as the worst case of hare lip ever born into the world. What a recompense for the privilege of marriage! That much for the direct effect, and still this couple produced offspring that have yet to be heard from. Another instance was illustrated by two cases very similar to each other. In both the husbands suffered from primary syphilis. The wives contracted it and a few years later both husbands and wives developed locomotor ataxia. Again what a recompense for the so-called privilege! If the many instances of this kind were made fully known to the public, would we need a law to save our women from taking such a chance on marriage?

Gonorrhea is another disease that spreads its train of bad in-

heritance and an even greater damage through contagion. The male laity regards it as of less importance than syphilis so there is more of it uncured, because of its greater prevalence, of course, but also because less attention is paid to it by its victims, in following it to an absolute cure. Most gonorrheal patients take treatment assiduously while the disease is active. Their physicians advise them that there is great danger of infecting others until the gonococci have entirely disappeared from the urethra, but many patients do not accept this as a fact or they are willing to take a chance on it. Some, then, in spite of this emphatic warning, persist in marrying while yet the poison is present within them. The circumstances of marriage serve to light up the smouldering flame and infection of another innocent victim results.

From the same source, the condition being transmitted to the mother, come cases of infant infection, of ophthalmia neonatorum. Too often do we witness this dual sacrifice, the wife contracting gonorrhea and through no fault of hers the new born infant develops a purulent ophthalmia. Through the generative organs of the young wife the disease spreads like wild-fire. She is unsexed by the resulting pyo-salpinx or the operation that frequently is necessary to save her life. In spite of the best effort the infant may be blinded in one or both eyes. What a train of tragic results caused by the one who in all things else would lay down his life to save those whom he has unwittingly harmed. To prevent the disastrous transmission of this one disease alone, is not a compulsory physical examination of the male candidate for marriage well justified?

When the microscope and other laboratory methods were brought to bear upon gynecologic diagnosis some startling discoveries were made. Reliable men declared that a vast number, some said ninety-five per cent. of cases of disease suffered by women patients was due to gonorrheal infection. Knowledge of the circumstances showed that most of these patients contracted the disease from their husbands. While the more conservative do not admit the larger per cent., all agree that by far the majority are due to gonorrhea. Think of this, of the statistics familiar to all of you and of the cases which you know of personally. If these husbands inflicted damage upon their loved ones in any other manner, knowingly or not, would we rest until we made sure of protecting them? Would we not go to any length to prevent similar damage to others? If the

circumstances were reversed, if the wife were the aggressor and the husband injured, wholesale numbers of them, would not the matter be settled in a manner capable of absolutely protecting the male and that, regardless of sentiment and all else but the further avoidance of such danger.

If the public but knew the full truth, an instinctive sense of self protection would do much to settle this problem. But the very people who risk most the danger know least about it. If they will in earnest consider this phase of marriage, such tragedies will lessen materially. Medical men as a rule do warn their *male* patients as to the danger of marrying while yet the slightest vestige of the disease lingers. They advise them sincerely that venereal disease usually can only be cured after long continued and thorough effort and that there is grave danger of infecting others until the poison is entirely eradicated. But these measures are not sufficient. Women must learn the full truth, distasteful as it may be. Parents must assume some responsibility and learn enough concerning venereal disease to protect their daughters.

Establish a law and enforce it but let us not rest there. The real good will come by educating the people at large regarding this subject. Teach mothers the true facts and when their daughters are about to marry, raise the veil of false modesty and pass on the information. Heretofore they have gone blindfolded into conditions that chanced their health and their very life, and the health and life of their offspring.

Of greater importance, let fathers learn concerning the physical condition of their prospective sons-in-law. A searching scrutiny will do much to prevent this greatest danger to women in marriage. Teach women to believe that the health of their daughter's life companion merits at least the same consideration as does his social standing. Teach fathers to believe that his physical condition means far more than the size of his salary check or his yearly income. Let them once grasp fully the danger chanced by the young woman in a marriage heedless of these matters, and they will rise to protect her with their whole strength and effort.

This work of teaching, of proving, of demonstrating these things to the public, is our work. We must let conventions and sentiment go in a great measure and seek to establish broader and more honest methods of presenting this subject. Our ethical relations with male patients need not be disturbed, but we



must stand firmly in protecting women. We must treat this contagious disease as we do other contagious affections and devise means whereby it may not be spread. The diffusion of knowledge in proper directions will serve to establish higher standards. The establishment of higher standards among people will make many young men strive to live within their pale.

When they know that to marry they must show a clean bill of health regarding certain diseases, the effect will be a salutary one. Farther reaching and more effective will be this demand of the people, this physical standardizing of matrimonial candidates, and soon men will strive to live so that they shall be free from disease, that when they come to be weighed in the balance they shall not be found wanting.

Other diseases may be listed in the above category. Epilepsy and a variety of mental disorders are capable of leaving their mark upon offspring. The public is likewise ignorant of these conditions. Again it will protect itself if aroused to the need for such protection.

As a society, and as individual physicians we are enlisted on the side of eliminating this prolific source of disease. Our duty is three-fold: to advocate the establishment of a law to govern these conditions, to supply the necessary data upon which a capable law may be based and to educate the public so that they may co-operate intelligently with the law and increase its good effect by voluntarily raising their own standard of requirement.

Give us a law to protect those who are unable or unwilling to protect themselves. The law must have authority to make proper surveillance, for even in the face of danger some people will practice deception. The details of that law may be worked out as experience teaches. Make it in good faith, for the single purpose of preventing marriage among persons who are physically unfit. Let the law be universal, a Federal statute, so that the expedient of securing a forbidden license in another town or in another state may be impossible as a means to defeat the intention of this timely statute. The need is universal and so the law should be.

Fragmentary laws exist in some commonwealths to-day. Gonorrhea, syphilis, insanity, tuberculosis and other diseases are under the ban in a few places. These local laws do little more than make marriage more or less inconvenient among those to whom it is forbidden. They, however, call the atten-

tion of thinking people that there is danger in the conditions named and they indicate that earnest men are considering this subject.

To prevent the continuance of an awful sacrifice of health and life, we must have a universal law prohibiting marriage among persons suffering from tuberculosis, syphilis, gonorrhea, epilepsy and insanity. That law must authorize the examination of male applicants for the marriage license for evidence of the above diseases. Let this be a good beginning. The question of whether female candidates shall be examined for evidence of tuberculosis, epilepsy and insanity may rest while we establish the other and rather more important standard and while we educate the public to the great need for such control. All great movements affecting civilization have been perfected by degrees. The remainder will be more certainly accomplished by demonstrating the efficacy of the first part.

Somewhere this law, with full authority to enforce it, must be first established. Where better than in Maryland, where so many forward movements have begun. Medical men, by education and by training are the ones to make possible this law. Let the Maryland State Homœopathic Medical Society at this meeting start the movement forward. Give us a committee empowered to investigate the subject and make recommendation necessary to the establishment of a law. Let it be a permanent committee, its work to be accomplished only when it succeeds in securing the passage of this statute. Let it investigate widely, secure the necessary data and lend its help to other organizations that in future may enter upon the same work. Let this committee work as the vanguard, the leader in a movement to give Maryland a capable, effective statute of the kind and then carry the work into a wider field by making the same effort for a Federal statute, the enforcement of which alone can accomplish the object desired. It is a big work, and will require much time and effort, and capable, systematic organization of all resources to successfully handle this great world problem. But if to-day we will start the movement forward and from now on work earnestly for its accomplishment, success will eventually come and the effort will stand everlastingly to the credit of our Society, and help bestow a wonderful amount of good upon mankind.

THE PRESENT STATUS OF HOMŒOPATHY. PRESIDENTIAL ADDRESS  
DELIVERED BEFORE THE NEW JERSEY HOMŒOPATHIC  
MEDICAL SOCIETY.

BY

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BEFORE proceeding with this address I desire to remind you for the moment of the large number of papers on the program which consider the relation of homœopathy to other newer methods of treating diseases.

I admit that there has been some pre-arrangement in this matter but nowhere near to the extent that the number of such papers might lead one to surmise.

The situation simply makes evident the fact that there is much and general thought on this very phase of the matter. If, as a result of these coincidences, there be many identical cross references and perhaps repetitions, still the circumstance is not without advantage, for just so may we the better arrive at the truth.

A few weeks ago, while this address was in process of forming I was reminded of these few lines from Oliver Wendell Holmes:

"New occasions teach new duties;  
Time makes ancient good uncouth;  
They must upward still, and onward,  
Who would keep abreast of truth."

How much the doctor needs to keep these thoughts in mind—The Doctor—of every age; of every school; the doctor: jealous through the thousand and varied confidences reposed in him; harassed by poverty; exhausted by work or starved through lack of it; benumbed by the chill of failure or warped by the heat of success; bound to his post by the fetters of duty he could not, would not loose—grinding his life away in a groove which becomes deeper and deeper, his mind and his methods narrowing themselves in their old confines, as the dying snail withdraws itself to the vanishing point in its old habitation.

Up and out of it!



It is now one hundred and twenty-two years since Hahnemann first gave to the world his conclusions that the sick could be cured by administering those drugs, which, if given to them when in health would produce the same symptoms and similar conditions to those from which they now ask relief.

What is the relative value of that method to-day? Reliable statistical reports may not be necessary to prove a theory, but they are essential for the establishment of a successful method of procedure,—and at present *we have no recent reliable statistics* of the results of homœopathic prescriptions. The *good* results have been observed so long, and in many cases have been so combined with other methods “to help the case along,” that we have ceased to make numerical reports. There is one exception to this last statement,—there is a report recently issued (by Dr. Dewey, of Ann Arbor, in *Medical Century*, February, 1912) concerning the relative values of homœopathic and antitoxin treatments of diphtheria—and I mention it but to condemn it. The statistics themselves are incomplete and the conclusions, even in the face of the statistics, are unworthy the man or the school he represents.

The statistics recently issued by the “American Institute” concerning the bacterial diseases, are very favorable to homœopathy—but they cover a period, hence include mortalities, of a hundred years ago. This latter fact renders them undesirable to science; for the methods of treating diseases, other than by homœopathy, have improved tremendously in that time, as all will concede. If we are to offer statistics, they must, to be of value for comparison, be of recent cases and above all, unbiased. It is a deplorable fact that we have at present no such statistics. We do not have enough definite reports of cured cases,—and I recommend that their collection be started at once. In these reports, extreme care, yes, I should say imperative care, is necessary to differentiate Coincidences from Consequences.

In the eternal struggle for the survival of the fittest, what, in the realm of medicine, is the present-day status of homœopathy? An answer to this question is demanded from several quarters. From the laity,—who are harassed by the question while in the throes of illness; to them it comes, if not from their own previous consideration of the matter, then from anxious relatives and friends: from the would-be medical student, to whom the matter is a real scientific and business concern;

from the various educators over the whole world; from the leading and progressive members of the dominant school; and most important, most significant, the question comes from the members of our own school,—from ourselves to ourselves.

Is the study of homœopathy worth while? Is it of any particular value to employ a homœopathic physician? Is it worth the necessary effort, to continue this eternal studying; this wading through tomes of *Materia Medica*; this burning of the midnight oil and consuming this precious energy?

Can we cure our cases more speedily, more completely, and a greater proportion of them, than our regular-school competitors? Granted that we do, is there *enough* superiority to warrant or induce a continuance of this special course in homœopathy, and its unceasing study?

Why, if we have the only “law of medicine,” if we have the only system which pretends to a semblance of perfection, why then are not we the dominant school? Why are not our colleges, our societies crowded to the door, our ranks so full there is no room for more? Why have we been compelled for fifty years to fight for the maintenance of our very existence? Why at this late date, in this age of ready acceptance of all that’s proven good, why must we send out a propaganda of homœopathy?

It is *not*, as some would claim, because we have not practiced the tenets of our school with sufficient zeal and persistence, but in spite of it—in spite of all our endeavor, of all our triumphs at the bedside; after a century of unremitting study and faithful application, we are yet only a minor school of medicine. *The status of our school to-day is not what its foundation on a fundamental law should warrant or deserve.*

Fifty years ago, homœopathy had nothing to compete with but the prejudice of the dominant school and its followers among the laity, but in that intervening fifty years there has been marked progress in the whole field of medicine:—The finding of anæsthetics; the discovery of the causes of disease and thereby an immense reduction in the mortalities therefrom—notably, malaria, yellow fever, the plague, cholera, cholera infantum, etc.;—improvement in the preparation and application of vaccine and a clearer perception of its values and limitations, until small-pox has by it, combined with better quarantine, been almost eradicated from the earth; the attainment of asepsis in surgery and the consequent brilliance of the achieve-

ments in that branch; the better appreciation of the value of massage, and improvement in its application; the swift progress in the march of achievement by electricity; the discovery of the Roentgen ray with its marvels of diagnosis; the perfection of apparatus for the production of high-frequency and high-tension currents; a better appreciation of the values of galvanism and faradism; the realization by the dominant school that the methods of drug administration, in vogue with them, were usually more harmful than helpful; the lessening of this harm by the lessening of the dose; the search for and triumphant production of drugs which are of real value both as local and general germicides; of other drugs which are of real value in the temporary relief of pain; of still others which have the quality of combining in the body with effete matters in the tissues thereof, and forming new compounds which are of easier elimination, thereby relieving the body by hastening the latter function; the discovery of antitoxins, followed by its ever-growing glow of promise of the ultimate annihilation of mortality from those dread diseases—diphtheria and tetanus; the discovery and perfecting and cheapening the cost of Pasteur's prophylaxis of rabies; and now to crown all, come Behring, Pfeiffer, Weigert and Ehrlich, with the latter's host of followers, bringing Ehrlich's "Side-chain Theory" of disease production and cure. Still further, based on this "Side-chain Theory" come Ehrlich again and Wright, with their bacterins and opsonins—the one for prophylaxis and cure, the other to diagnose and measure the intensity of disease, and the patient's capacity to combat it.

A brilliant and dazzling array of triumphs,—and one that makes for the confidence and comfort, health and lives of the human race, and while some of it may have been incited directly or indirectly by the methods and success of homœopathy, in none of it has been the hand of a man who practiced or acknowledged a belief in the law of "Similia."

It is certainly not surprising then, that the man who is preparing to study medicine, desires to affiliate himself with that school which has been able to show such marks of real progress as is evidenced by the works of the dominant school and their co-laborers in recent years.

Has homœopathy kept pace? Are we, as a school, better prescribers than we were fifteen years ago;—so much better as to attract anybody's attention to it? We think not.

True, we have kept a fairly even pace with the old school



in their own work with surgery—in some individual instances, actually led them. But not as a school. Have we, on the other hand, been able to lessen the necessity for surgical operations, by any improvement in our work with the similar remedy? We think not. Have we accepted promptly, the now undoubted findings of the scientists regarding the bacterial factors in the cause of disease? We did not—we were slow. When we did accept them, it was grudgingly—and even now there are many among us who have not yet acknowledged these truths.

And what of our reception to antitoxin:—that saviour of human life; that harmless, positive cure for that dread disease, diphtheria; that exact supplement to Nature's efforts to throw off the strangling yoke; that substance which was discovered, according to von Behring himself, as a result of the contemplation of the action of homœopathic remedies? Shameful! Shameful alike, to our calling as physicians; to our claim as a scientific school. We refused to try it; we refused to believe the reports of others who did; we forgot the admonition that "that physician who refuses to apply a remedy of known value, to the saving of human life, is guilty of a crime!" Oh, homœopathy, then what crimes have been committed in thy name!

And now what shall be our attitude toward Ehrlich's offering? Shall we say: "Ehrlich is not a homœopath, therefore go hence—we will have none of it—we will not try it—we know nothing about it;—it is not offered by a homœopath, therefore it is no good"?

Fellow Homœopath, I pray, I implore you, to assume no such attitude.

I would not have you thrust upon your trusting patients every new thing that you hear about, just because it is new—that will make you a faddist. *Nor* on the other hand, would I have you *refuse* to study thoroughly and apply, when its value is shown, *anything* offered which promises to relieve suffering or save human life, regardless by whom that offer is made;—such refusal will make you a bigot.

I have read some of Ehrlich's writings concerning this "Side-chain Theory." I have studied the works which others have written about it, and with your permission I will *very briefly* state my conclusions regarding it—conclusions which I very greatly desire to see put to the test of verity,—at the bedside, in the laboratory,—to be accepted if true, to be cast aside if false.

The "Side-chain Theory" explains:

Nature's method of taking up food by the needy cell; the manner in which the cell is injured by the presence of poisons; the method of killing germs in the blood; the method of cell reproduction and the process of repair; the method by which the injured cells, be they of the blood or the tissue, make use of substances administered to them to aid them in their efforts at self-defense, and ultimate immunity. He emphasizes the "essential power of the life" in the cell—the "Leistungs Kern." (Bolduan: "Immune Sera," p. 8, New York, 1911.)

In the course of his experiments, Ehrlich demonstrated the presence of partially decomposed or "attenuated" poisons, to which he gave the name of "*Toxoids*." He further showed that the presence of these "toxoids" were possibly always necessary, frequently responsible for, and could, in various diseases (as typhoid, rabies, staphylococcus infection and some others) be called upon at will, to set up an artificial, if partial and temporary, immunity. The "toxoids" incite the formation of *sessile receptors*, which are the *cells' protection*, and probably *the first step in the formation of free receptors*, which is *immunity*. Some of these "toxoids" are now sold on the market under various names,—vaccins, bacterins, etc. (the latter of which names, it seems to me, should be generally adopted, as preventing confusion with the living virus of cow-pox—with which it has nothing to do).

It has appeared to me that these "toxoids" find their exact analogy in the *attenuated* similar remedy. In order for either to perform its function, it must be correctly, appropriately chosen, and the cells upon which it is expected to act must still be capable of reaction.

Ehrlich has further shown how minute may be the injurious dose of any poison; how small is the dose of toxoids necessary for incitement to defense; how aggravations are produced; the value of the repetition of the dose, etc.;—in fact, it seems to me, he has unintentionally, and perhaps unconsciously, made clear to us many things which we have wished to know concerning the law of similars.

And if these and many other correlated conclusions, can by experiment and observation be verified, then Ehrlich has brought to light the many hitherto invisible links in the chain which binds Hahnemann's law to the other natural laws governing God's universe.

Homœopathy is a method of treating disease by the adminis-

tration of drugs, the selection of which is made in accordance with the natural law which is expressed by the phrase, "likes may be cured by likes." This law has been verified thousands upon thousands of times—is in action now, and will be for ever more, or so long as the human race remains subject to disease, and until some other, better law shall be discovered to supersede it. It was the first, and is yet, the only dictum regarding the general prescribing of drugs which has withstood the test of practice for an hour.

This law is as immutable as the law of gravitation; as universal as any of the laws of light, and requiring for its fulfillment a no less complex of environment than that necessary for the action of any other phase of the laws of stereo-chemistry, of which it is a part. It remains for us, segregated as we are by the dominant school, because of our belief in homœopathy and their denial of it, for us, I say, to so perfect our application of it; supplementing it wherever supplement is possible; seizing upon everything of possible value in the pursurance of our profession—studying everything, testing everything of promise, first in the laboratory, then at the bedside, leaving nothing of real value get by us, but by adoption make it *ours*, until we stand not only as the *school of permanence* upon our *law* of cure, but *also* as the *school of progress*—fearing not to face or use the truth regardless of its source;—then, and only then, can our rightful status be assured.

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## CHLORINE TREATMENT OF SEWAGE.

BY

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(Read before the New Jersey Homœopathic Medical Society.)

THE disposal of its sewage is one of the vital problems for a community to solve. Local conditions should be considered as to the method of disposition. Sewage consists of about 999 parts of pure water to 1 part of impurity, about one-half of which is organic impurity and bacterial life. Sewage disposal then deals with this small fraction of five one-hundredths per cent.



A perfect disposal of sewage would consist of the reduction of this organic matter into a mineral form and the destruction of this bacterial life. It is with the destruction of this bacterial life and especially of the pathogenic bacteria that the disinfection of sewage has to deal.

The common methods of sewage disposal are:

(a) The so-called "Farming Process" when the sewage is deposited upon the open surface. It is adapted to sandy soils and small inland communities. It requires an acre of ground to every 1,000 people which is prohibitive for large cities.

(b) The sand filtration by means of tanks and the effluent discharge into streams. This removes the suspended matter but it is now generally agreed not to rid the effluent of bacteria, hence if it contains pathogenic bacteria it becomes a menace to towns below.

(c) The ejection of crude sewage into a running stream depending upon the power of running water to purify itself, which power it has up to a certain degree. If the stream is swift and the degree of pollution not too great, it can take care of crude sewage. This has a rather agreed limit of one part to fifty. Above that the stream is robbed of its oxygen and thereby of the power of self-purification causing the death of fish and animal life and becoming an open sewer. If the stream is slow and the proportion of sewage high, greater precaution should be used in removing the suspended matter to prevent sedimentation, and then the disinfection of the effluent.

(d) The ejection of sewage into tidewater. This applies to cities located along the coast or upon tributary streams affected by tide, this includes most of the large cities of the East, as New York, Boston, Philadelphia, and in particular from the standpoint of this paper to seashore resorts. The nuisance here of crude sewage consists of the infection of shell fish with pathogenic bacteria especially of typhoid and coli bacillus, also the unsightly appearance of suspended matter floating on the surface and deposited upon the beach. Ocean City passed through this experience in the summer of 1910 when a considerable number of cases of typhoid fever developed among the summer visitors. The infection was almost exclusively confined to the patrons of the better class of hotels and of those that served oysters and clams on the shell. The local residents nor the cottagers were affected. This fact would

eliminate the water and milk supplies. The reason of the infection was the serving shell fish taken from the bay water into which the sewer emptied.

The disinfection of sewage can be combined with any or all of the above methods of disposition. Ideally that should be done and so infection from pathogenic bacteria eliminated from all sewage effluents. Obviously, however, the degree of purification for safety varies with the local conditions and unnecessary expense should not be burdened on a community when the limits of safety are maintained at smaller expense. For instance the effluents thrown into a big body of tidewater should not require the degree of purification as that thrown into small fresh water streams.

The idea of sewage disinfection is not new but the agents used were so expensive as to make it prohibitive. The chlorine treatment is at once effective and economical. The agent is ordinary bleaching powder from which chlorine is liberated. Bleaching powder is obtained as a by product of the caustic soda industry by electrolytic processes at Niagara Falls. The present market price is about \$25 a ton. The cost of disinfection depends upon the degree of purity demanded.

Extensive experiments have been made at Baltimore and at Red Bank, N. J., to determine how much bleaching powder per million gallons it takes to get a definite bacterial efficiency. The quantity required is surprisingly small. At Baltimore it was found that three parts of available chlorine to one million parts of sewage would give bacterial efficiency of 97 per cent. for sewage effluents, that means sewage that has already been filtered. For crude sewage about five parts per million is required. In the former case the cost is about \$1.00 per million gallons and in the latter about \$1.70 at the market price of \$25 a ton for bleaching powder.

The smaller amount of chlorine acting for a longer time will give an efficiency equal to larger amounts of chlorine acting for a shorter time. To lengthen the time sewage is acted upon means the passing of the sewage through tanks. Here the first cost is greater but the amount of bleaching powder required is less. The operation of the plant is automatic and hence the operating charges are small. When stronger solution of bleaching powder is used not so much time is required and the installation of tanks may not be necessary. Here the first cost is less and the operating expenses higher. Atlantic

City uses the latter method. It has a run of over a mile before emptying into the bay and by using stronger solution of chlorine it depends on the disinfection to a safe degree before it reaches the bay and thus the use of tanks is avoided. Ocean City has only a short run before emptying into the bay hence it is necessary to run it through tanks.

The principle of chlorine treatment and what bids fair to prove the most efficient disposition of sewage is now exemplified in a model way in the plant as established in Ocean City. The sewage is received into automatic ejector tanks. The ejectors force it into a receiving tank where the heavy solids are screened out, thus eliminating the masses of suspended matter. It then passes through a series of concrete tanks flowing over the tops of the tanks upon which are further screens for removal of solids. It finally comes to the treatment chambers where the chlorine is added automatically and a period of two hours allowed for treatment on a basis of three parts of bleaching powder to one million of sewage.

One dollar a million gallons for bleaching powder and one man can operate the whole plant and the sewage is emptied into the bay clear as drinking water, free from all suspended matter and practically free of bacteria with no odor and without any harmful effect on the animal life in the stream.

The points I desire to bring out in this paper are that some degree of sewage disinfection should be considered a sanitary necessity.

That the chlorine treatment can be adapted to every good method of sewage disposal.

That the method is efficient and the cost not prohibitive.



**AN UNUSUAL CASE OF PNEUMONIA.**

BY

V. A. H. CORNELL, M. D., TRENTON, N. J.

(Read before the New Jersey Homoeopathic Medical Society.)

It is not my intention to take up this subject in the usual way, that is by describing the pathology, symptomatology, etiology, etc., of this common and prevalent disease, or to try to give you anything that is new in regard to its treatment that would give our little patients any more comfort or to get them out of their beds any sooner, as you all probably have had a number of cases to study and treat during the past long and severe winter, and are therefore most familiar with the condition. But sometimes we meet during our practice a common disease which presents most uncommon and unusual symptoms. I had the fortune, or perhaps the misfortune, to have recently such a case in my practice. A case of pneumonia coming on suddenly in a bright, healthy boy between two and a half and three years of age and attended by a very high and persistent fever, continuing with severe symptoms for seventeen days without a crisis, and terminating unfavorably. So I thought a recital of this case, instead of the usual paper, might be interesting to some of you, and that the discussion which I trust may follow instructive to a few.

On February 14, 1912, I was called about 11 P. M. to attend A. C. R., a boy two and one-half years of age who was just about recovering from quite an active convulsion. The temperature by rectum was 106 degrees F. The face was pale and there were some slight twitchings about the mouth and eyes. The child had been placed in a hot bath before my arrival, and was still lying in some wet towels. An enema was ordered producing quite a large and undigested movement. After getting some dry clothes on the patient he was put to bed and seemed much quieter and easier, although the breathing was rapid and somewhat difficult. I remarked that the child seemed to have quite a cold; the parents, however, said that he had been entirely well up to the time he was taken with the convulsion, or at the most an hour or two before.

Owing to the lateness of the hour and the fact that the

child was inclined to sleep I did not at that time disturb him for a chest examination.

The next morning the temperature was still high, 105 degrees F., and the breathing very rapid and difficult. Upon examination there was dullness on percussion over the base of the right lung. Auscultation revealed the breathing sounds over this portion to be weak and distant, and there were some fine crepitant rales. The left lung was entirely clear. There was pain in the effected side, and a short dry cough. The pulse was 110 and respirations 40. I ordered a mustard paste put over the right side and prescribed aconite 3x.

Upon my next visit late in the afternoon conditions were unchanged. A trained nurse was secured and the orders were: Plenty of fresh air, temperature baths of 70 degrees every three hours, a milk diet, water ad lib, and the aconite was continued.

On the third day of the disease the temperature ranged between 103.5 degrees and 105.2 degrees, pulse 120 to 144, strong and regular in character, and respirations 36 to 50. The remedy was changed to bryonia on account of a short dry cough which gave the child a great deal of discomfort and pain. There was considerable twitching of the muscles and jumping in the sleep, but this I attributed to the high fever.

On the fourth day the symptoms increased in severity, temperature between 105 degrees and 106 degrees most of the day, pulse 130 to 144, respirations between 44 and 56. The lung involvement did not increase perceptibly. Bryonia was continued.

On Sunday, February 18, the fifth day the child was very nervous and delirious, seemed very much frightened and was afraid of falling, respirations and pulse very rapid and temperature high, 105 degrees to 106 degrees. Hyoscyamus tincture, one drop every hour until quiet, was ordered for the nervous condition. This symptom became so troublesome that one-half grain of Dover's powder was also given. Some symptoms simulating meningitis were present at this time, slight rigidity of the spine with limbs contracted and stiff. The child passed a very restless night, and as there was no abatement of the symptoms and a very sick child on our hands, I suggested a consultation. The family had two cousins who were allopathic physicians practicing near Trenton. They were called in and advised consulting with Dr. J. P. Griffith.

of Philadelphia. Upon his arrival and after examining the case the other physicians agreed with my diagnosis of croupous pneumonia effecting the lower lobe of the right lung. But you may imagine that the treatment became quite allopathic instead of homœopathic from now on. The orders were tub baths at 100 degrees every three hours for temperature when above 103 degrees, brandy, 30 minims every three hours, and digitaline 1-100 grain every three hours. This treatment for twenty-four hours made no improvement as the condition early the next morning was: Temperature 105 degrees, pulse 144 and respirations 60. Antipyrene 1½ grains every two hours until temperature dropped to 103 degrees was ordered. Six of these powders were given and the temperature was brought down to 101.4 degrees; but shortly after this it began to rise accompanied by a very weak and rapid pulse for which strychnine 1-200 of a grain hypodermically was given. This was repeated in one hour, the pulse becoming stronger. Now nitroglycerine 1-200 and digitaline 1-100 every three hours was the order of the day with the addition of oxygen from the tank and a high saline enema.

Upon the morning of the ninth day the temperature was 105.4 degrees, pulse 152, respirations 58. At 10 P. M. the pulse could not be felt; now strychnine 1-150 grain was administered followed shortly by camphorated oil 10 minims, caffeine, 1 grain by hypodermic injection, and brandy, one dram, by mouth, frequently. Under this treatment the pulse became stronger, but the temperature was very high, 106.4 degrees, and respirations irregular.

Early the next morning respirations were very shallow and rapid, 80 to the minute, pulse 170. The pulse was now weak and irregular at times. There were several sinking spells for which camphor and caffeine and mustard packs were administered.

On the eleventh day of the disease at 9 A. M. the temperature was 105.6 degrees, pulse 192, weak and irregular, and respirations 104. Strychnine 1-60 grain was given. Later in the day the nitroglycerine and digitaline were changed for strychnine 1-150 and atropine 1-1000 hypodermically every three hours. The inflammation was now extending in the right lung, but the left remained clear, two doses of bromides, 5 grains each, were administered early the next morning for extreme restlessness. Two more doses of bromides later in



the day, also the nitroglycerine, digitaline and camphor again. About two drams of milk of asafetida was put in the rectum for abdominal distention, oxygen from the tank almost continuously, also turpentine stupes to the abdomen. The intestinal tract had been behaving very well up to the last day or two when undigested movements and abdominal distention began to give a great deal of trouble.

On the thirteenth day, digitaline, strychnine, nitroglycerine, atropine, and camphor were continued at different times during the day. Temperature 103 degrees to 105 degrees, pulse 128 to 168 weak and irregular, respirations 52 to 64.

On the fourteenth day at 7 A. M. the temperature was 101.6 degrees; but it did not remain so for very long as at 1 P. M. it was 105 degrees again.

Drugs were given about the same. The pulse was weak and respirations very difficult and rapid. High saline enema was given, also hypodermoclysis later in the day.

On the fifteenth day the condition was the same, if anything worse, as the little patient was losing strength rapidly; temperature reached 106.2 degrees, pulse 180, respirations 60.

Treatment was continued with the addition of two doses of eserine. 1-500 grain. The patient now swallowed with difficulty, and there were occasional twitchings of the muscles.

On the sixteenth day temperature at 5 A. M. was 101.2 degrees, pulse 150, respirations 54. Temperature kept fairly low most of the day, but the child was very weak and could not swallow; respirations rapid, difficult and jerky; patient unconscious, in fact had been unconscious most of the time for the past few days. Drugs and stimulants were kept up with regularity; 1-50 grain of morphine sulphate hypodermically was given on the evening of this day. Temperature at 10 P. M. 106 degrees, pulse 156, weak and thready, respirations 60. The little patient succumbed early the next morning with conditions unchanged to the last.

In summing up this case it may be said that the highest temperature recorded was 106.8 degrees, the lowest 101.4 degrees. There were at least fourteen sinking spells or attacks of collapse, when the pulse could not be felt for some time, and the child just barely lived only to revive again after the most heroic measures were used. The different drugs and stimulants with the total amount of same that were used in an endeavor to stay the symptoms of this severe attack were

strychnine sulphate grains 1-5, digitaline grains  $\frac{1}{2}$ , nitroglycerine grains 1-3, atropine grains 1-20, caffeine grains 6, antipyrène 14 grains, camphor 100 minims (this was a ten per cent. solution in almond oil; ten doses of ten minims each), eserine grain 1-100, morphine sulphate grains 1-50. These were all administered by the hypodermic method in divided doses. The following were administered by mouth: Dover's powder grains 2, bromides grains 30, brandy 9 ounces, strophanthus tincture 14 minims, hyoscyamus tincture, minims 6. Besides this, seven tanks of oxygen were used, and mustard baths, saline enemas, and hypodermoclysis were resorted to at different times, but with only temporary improvement.

Two nurses were constantly in attendance, and there was no time from the fifth to the seventeenth day of the attack that a physician was not in the house. My diagnosis in this case was, as mentioned in the beginning, one of a clear, uncomplicated croupous pneumonia effecting the lower lobe of the right lung and eventually the whole right side, leaving the left clear. An autopsy was performed on this case, and Dr. Griffith gave it as his opinion that our case was, after all, one of those unusual cases of pseudo-lobar broncho-pneumonia with onset like that of croupous pneumonia. This possibility he mentioned a day or two before the child died.

I have given you the facts of this case accurately, I believe, as careful notes and charts were kept by the nurses in attendance. I now invite your discussion upon the treatment here given, or upon any other phase of the case that may appeal to you.

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SERUM TREATMENT OF INOPERABLE CANCER. Schmidt says that during last two years the reported results of this treatment have varied, some showing cures and others failures. At present therefore it is not possible to reach a decision concerning its merits. As a contribution to the subject the author reports three cases of inoperable cancer of the cervix uteri treated by the injection of cancroidin or "antimeristem." One patient improved greatly in general health and was free from recurrence for two years, the other one and a half years, but in the third case the author recently saw the last trace of nodulation disappear."—*Zentralbl. f. Gyn.* 1911, 1711.

**POST-OPERATIVE BACKACHE.**

BY

HOMER I. OSTROM, M. D., NEW YORK.

(Read before the Surgical and Gynecological Society of the American Institute of Homoeopathy, Pittsburgh, Pa., June, 1912.)

THE backache following operations is frequently a most distressing symptom, and one from which the patient often suffers more than from any other. This is especially true after gynecological operations, and those involving a prolonged lithotomy position, or the dorsal decubitus, as in abdominal section.

The backache is usually complained of the day following operation, and may increase for several days, gradually diminishing in severity until at the end of a week it has entirely disappeared. Or in some instances it remains during convalescence or even after the case is dismissed as a surgical cure, giving rise to sciatica, and pain involving the genito-crural nerves.

The causes of post-operative backache are to be sought in a prolonged strain of the sacro-iliac joints due to the position of the patient during the operation, and as may be expected its severity and continuance are in direct ratio to the length of time consumed in the operation, and to certain structural peculiarities of the patient.

Anatomically the pelvic articulations are recognized as true joints, being composed of the structures peculiar to joints, and it has been demonstrated that there is a certain though limited degree of motion between the sacrum and ilium.

Though these joints may have other functions, a principal use of motion at the base of the spine is to break any jar to the spine and brain that would otherwise be transmitted during locomotion, and to avert direct expenditure of force upon the superimposed nervous structures. Physiological use therefore of these joints would seem to be in the long axis of the body, and not transverse to it, as must be the case during the dorsal position, continuation of which produces pathological strain.

Just anterior to the synchronoses the sacral plexus of nerves rests on the pyriformis muscle, the branches of which,



as well as the plexus being in close relation with the sacro-iliac ligaments. Any prolonged strain therefore, as a protracted illness, or the continued dorsal position following childbirth, or forced relaxation and effacement of the lumbar curvature during laparotomy or vaginal plastic work, is almost certain to at least temporarily cause a more or less severe form of nerve irritation, and a variable degree of pain in the back. In some instances this may far outlast the extreme limits of convalescence.

Our first concern will be to prevent as far as possible this distressing sequela of an operation by measures directed towards relieving the strain on the sacro-iliac joints which necessarily belongs to the operative position. With this object in view I am in the habit of giving support to the small of the back by placing a cushion, preferably a sand bag, something as hard as the operating table, in the lumbar curvature to build up the arch, thus relieving strain on the sacro-iliac joints, and the lumbar articulations, and preventing injury to the sacral plexus of nerves. This is especially desirable in the case of women, whose lumbar curvature is usually more marked than in men, and the resulting freedom from post-operative backache testifies to the efficiency of this step in operating room technique.

Post-operative treatment in the matter of allowing the patient freedom of motion, and early change of position also does much to counteract the evil effects of lying so long on the back. Unless counterindicated by some systemic or organic condition—but rarely encountered—my nurses are instructed to encourage patients to help themselves, and I always allow them to assume any position that may be comfortable and restful; in other words, I do all that I can to relieve muscular and nerve tension, which is always indicated by pain.

Following abdominal section such latitude is greatly aided by the use of a well-fitting binder. With this adjusted a patient moves more freely, with greater confidence, and is more comfortable in a variety of positions. I always have my laparotomy patients wear one for the two or three weeks following an operation.

For remedial agents we naturally turn to those known to attack muscular, ligamentous and nervous structures. Rhus tox., Bryonia, Cimicifuga and others will be thought of, but I have obtained the most satisfactory results from *Hypericum*

per. I administer it in the *ix* internally, and apply it locally in the form of an ointment:

℞ *Hypericum per. tinct.*, drachm one.  
Menthol, drachm one.  
Petrolatum, ounces two.

Menthol being added as a mild counterirritant, and because of the relief it affords in localized neuralgia.

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### A PLEA FOR THE CONSERVATION OF THE TURBINAL.

BY

L. E. HETRICK, M. D., NEWARK, N. J.

(Read before the New Jersey Homoeopathic Medical Society.)

SINCE the beginning of intranasal surgery, the operations evolved for the relief of nasal obstructions have been many and varied. Many of these operations to-day are mere matters of history in the development of the present-day operations. Some of them have their good points and some of them have no claim whatever on rational and conservative surgery. Many operators in considering nasal obstructions have in mind but one thought, and that is the creation of increased space or room in one or the other of the nasal passages. They have attempted to increase this space and to make the needed room usually, and most commonly, by the removal of a part or all of the turbinals. It is the purpose of this paper to discuss the question of which is best for our patient and therefore ourselves, the removal of a part or all of the turbinals or the correction of an existing septal deformity, either in the form of a spur or a deflection.

I shall not go deeply into the anatomy and the physiology of the nasal passages, as we are all more or less familiar with them. The nose is divided by the nasal septum into a right and left chamber or passage. The nasal chambers are for respiratory, olfactory, phonetory and gustatory purposes. You will see therefore that the nasal passages are not merely openings through which inspired air must pass on its way to the lungs, but they have a very important function. Air, before it

reaches the lungs must be moistened and raised to blood heat, otherwise upon reaching the lungs the proper chemical changes necessary for the proper oxidation of the blood cannot take place. This warming and moistening of the inspired air is accomplished in the nasal passages, by the turbinals or turbinated bodies. These are three in number, are located on the outer wall of the nasal chambers and are known as inferior, middle and superior bodies. Of these the middle and inferior are of clinical importance.

The sub-mucous tissue, covering these bodies, is made up largely of erectal tissue. This erectal tissue is generally distributed along the anterior border of the inferior turbinal and on the posterior ends of the middle and inferior turbinals. Its function is that of warming the inspired air and of regulating the amount of serous secretion. It is important that the heating and humidifying apparatus of the nose should be in good physical condition, as the lower respiratory tract does not secrete enough moisture for physiological or protective purposes, nor is it capable of warming the inspired air sufficiently to bring it to the body temperature without injury to its mucous membrane. So important is the proper and normal function of these swell bodies, or turbinals, that it has been said that a man who breaths through a perfectly healthy nose is entirely indifferent to the severest extremes of heat, cold, dryness and humidity; that the nose is capable of preparing a climate, the atmosphere of which can come in contact with the sensitive lung tissues without creating irritation.

The mucous membrane covering the whole of the upper breath-way, is filled with mucous and serum secreting glands, capable of producing hot water so rapidly that by the time the driest air reaches the larynx it is saturated with moisture and the temperature raised to that of the blood. The circulation of this mucous membrane, particularly that of the inferior turbinals, is most active and performs a very important part in the warming and moistening of the inspired air. A great necessity exists for us, therefore, to give the greatest amount of consideration and deliberation to these structures before operating.

Of all the causes of nasal obstruction, septal deformities are the most common and consist in the various deflections, exostoses and ecchondroses. These deflections vary from slight curvature of the septum from one side or the other, to the greater deflections where the convexity impinges upon the



turbinals themselves. In such cases, where there is from the high degree of deflection, more or less obstruction to the inspired air current and therefore a diminution in the proper functioning of the turbinals on that side, nature, in her efforts to re-establish the required moistening and warming surfaces, produces what is known as a compensatory hypertrophy of one or more of the turbinals on the concavity of the deflection; and so, when our patient comes to us for relief from the varied and many reflex conditions resulting from nasal obstruction, we are confronted with the question of what is best to do in the way of operation. Is it merely a matter of making room, or is it a question of making room and preserving organs essential to proper respiration?

Let us consider for a moment the causes of septum deformities. These may be classed in general, under two heads—traumatic, or accidental and developmental. Under the first head come cases of deformity directly traceable to an injury. Under the second head come those cases, and by far the greater number, where a deflection or deformity can be traced to improper development of the facial bones. The most common form which this maldevelopment takes, is that of a high arched palate, due, most commonly to a lack of development of the dental arch; hereditary and consanguinous marriages are also causes. It is here that many nasal deflections can be corrected by sending our case to the orthodontist if discovered early enough.

However, our case not having been sent to the orthodontist as a child, comes to us as an adult with a deformity of the septum and more or less obstruction to respiration and we are confronted with the question how we can best relieve our patient's suffering and conserve the normal functions of the nose. Are we justified, as many surgeons do, in merely removing a part or all of a very important organ, the turbinals, or is it not better surgery and more conservative to correct the existing septum deformity? I ask these two questions because in the minds of many nose and throat men there is a difference of opinion. In my mind, however, there can be but one course open for the conscientious, painstaking specialist, that is, to determine primarily the cause of the obstruction; is it due to a deformed septum or an hypertrophied turbinal, and what should we do for this particular case? There are, of course, occasional cases of true hypertrophy of the turbinals which

must be considered and operated, but where we have a deformed septum and a compensatory hypertrophy, the septum deformity should be attended to first, as almost always the compensatory hypertrophy will adjust itself satisfactorily after the septum has been straightened and normal respiration restored. Given a case of deflection with more or less obstruction in one or both nostrils, and realizing the importance to respiration of the turbinals and their functions, what right have we, as surgeons, to remove from that patient's nose a part of an organ necessary to that patient's health, simply because we are too lazy to do the more difficult, but more rational operation? There is but one course open and that is the correction of the septal deformity, whatever it may be.

Having arrived at this conclusion our next consideration is what is the best septal operation to perform. Formerly spurs were removed by the saw, the operator removing the spur and its mucous membrane covering, leaving an area the size of the base of the spur, uncovered by mucous membrane, and which heals with scar tissue forever leaving a dry spot in the patient's nose. Deflections were reduced by various methods with crushing instruments, all more or less barbarous, and at best leaving the patient and the operator both unsatisfied.

To-day septal surgery has resolved itself into modifications of one operation, viz.: the sub-mucous re-section, and I shall, with your permission, give a more or less detailed description of the operation as it is now performed.

*First.*—Thoroughly anesthetize the mucous membrane lining both nostrils by the application of a local anesthetic. In my practice I use equal parts of a 4 per cent. solution of cocaine, freshly made, and a one to one-thousand solution of supra renaline (Armour). This I apply by means of a swab, repeating the application until the entire membrane is thoroughly anesthetic. Having thoroughly anesthetized the case, an incision is made anterior to the deflection on its convexity in a vertical line through the mucous membrane and perichondrium and extending from the top of the septum to the floor of the nose. With great care we next elevate the mucous membrane and perichondrium from the convexity of the deflection. This is done with specially constructed elevators. Having dissected up the membrane and perichondrium from the entire convexity of the deflection, it is lifted to one side by means either of a plug of cotton or a retractor in the hands of an as-

sistant and the cartilage is perforated in a line parallel to the first incision but back of it a couple of millimeters without puncturing the mucous membrane on the opposite side. This opening, or button-hole, in the cartilage is extended up and down as far as possible. An elevator is now introduced into the button-hole and carefully and gently the mucous membrane from the concave surface is elevated in like manner to the opposite side over the entire extent of the deflection. Having thoroughly elevated the membrane and perichondrium on both sides of the septum, the next instrument brought into play is the Ballenger swivel knife. This is introduced through the incision in the mucous membrane, one prong on either side of the cartilage of the septum and the entire deflection removed. This may not be accomplished with one attempt, two or more may be necessary. Having removed all of the deflection possible with the swivel knife, great care being used not to puncture the mucous membrane, we carefully inspect our field to see if there remain any overhanging pieces or any exostoses along the septal ridge of the hard palate, going back as far as the vomer. If there remain any thickness or overhanging pieces, these should be removed by means of a pair of septum cutting forceps. Having removed all the deflections and all the projections, we replace the two layers of mucous membrane and perichondrium in their proper position, holding them tightly pressed together by means of Simpson's sponge splint; or a nasal tube may be introduced into one or both nostrils and cotton packed around it, the main idea being to accomplish a perfect coaptation of the two perichondrial surfaces. These dressings are left in situ from twenty-four to forty-eight hours, after which they are removed and the case subsequently treated by means of emollient and healing applications. Before introducing the splints they should be well covered by some unguent.

This, in brief, is a sub-mucous operation; it, or some modification of it, can be done to cover any septal deformity. It has the advantage over other operations in that you have less danger of perforation, you will have a perfectly straight septum and will retain *in tact* the mucous membrane on both sides of the septum, with its functions unimpaired.

The question has arisen as to the advisability of removing entirely the septal deflection, as to whether it does not weaken the nose and tend to further deformities in the way of a collapse of the bridge, etc. Experience has shown us that this does not



occur, and that while new cartilage does not re-form, microscopic examinations of septums so operated show that there is developed a very dense scar tissue which is quite as useful as the original cartilage.

In closing, let me reiterate, before operating consider well the question of removing a part of a turbinal or of correcting septal deformities. Never remove a turbinal if by correcting a septal deformity you can accomplish your result. Almost any operation on the septum which will correct the deformity, is better than removing any part of the turbinal, and of all septal operations the sub-mucous resection or a modification of it is the best operation and will suffice for almost any case. It is a major operation; it is difficult to perform and should not be undertaken by any one without first having seen several done by an experienced operator.

#### DISCUSSION OF DR. HETRICK'S PAPER:

DR. HAROLD FOSTER: I want to commend Dr. Hetrick upon his missionary work in nasal surgery. Conservation of the inferior turbinates is the most important duty of every rhinologist.

To see a nose where the inferior turbinates have been removed, with a resulting purulent rhinitis and a dry pharyngitis, is discouraging to the surgeon, to say nothing of the feelings of the patient.

During the last decade remarkable strides have been made in nasal surgery, because the sub-mucous re-section of the nasal septum has been developed. The operation, when indicated and if properly done, accomplishes the benefits of space for nasal respiration and removal of contact between two mucous surfaces, without injury to the nasal mucous membrane which is the important physiological organ of the upper respiratory tract.

Obstructed nasal breathing may come from a disturbance of the vaso-motor nervous system which is evidenced by intermesant or alternating nasal obstruction. This is not a surgical condition, but is a local manifestation of a constitutional fault.

Aseptum whether deflected or thickened and causing pressure on the outer nasal wall produces a retention of the normal nasal secretions or may obstruct the outlet of one or more of the sinuses. Retained secretions make an ideal culture media for bacteria, and as almost every known bacteria is present in the nasal mucous membrane, the result of the contact is a growth

of pathogenic bacteria. There may be repeated acute inflammatory lesions simulating acute rhinitis, or there may be a constant formation of pus and post-nasal dropping.

The ordinary case of acute rhinitis begins on the side of obstructed nares, and patients who have had the persistent catching cold habit are relieved of this trouble after a sub-mucous resection.

Another condition in which a sub-mucous resection is indicated is in atrophic rhinitis where the cause is a thickened septum pressing against the middle turbinates causing obstruction of free drainage from the frontal sinus, antrum, and anterior ethmoidal cells. Even if pus is present a sub-mucous resection should be done. Sometimes it is necessary to follow these post-operative conditions by the Dowling tamponade.

The majority of pulmonary tuberculosis cases have obstructed noses, usually from an abnormal septum. This led me to do the sub-mucous operation on several incipient cases, all of which are now benefited greatly, or have no active signs of tuberculosis.

The inferior turbinates have been cut away quite unscrupulously. But the nose and throat men have found that a more serious result was incurred by establishing space at the expense of that important functioning tissue.

Regarding the technique, each man follows his own details. But as long as the important features are accomplished, i. e., the removal of the deflection or thickening, with no perforation of the mucous membrane and with enough hard tissue left for a support, the sub-mucous resection is the panacea for all nasal obstruction, giving both local freedom of air space and resulting improvement in the patient's metabolism and general condition.

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ON A NEW METHOD OF TREATING ACUTE GONORRHOEAL CONJUNCTIVITIS.—The treatment is based on the fact that 44 to 45 degrees centigrade suffices to destroy gonococcus. The writer has devised an electrical apparatus by means of which steam can be applied to the lids without annoying the patient with drops of condensation. Fifteen eyes with gonorrheal conjunctivitis were subjected to this treatment. In ten the cornea was clear on admission. In these a speedy cure was effected without involvement of the cornea occurring. In the other more unfavorable cases the inflammatory process was checked. In two eyes which showed almost complete suppuration of the cornea, some vision was preserved with the aid of conjunctival plastic. He considers this method unquestionably superior to the silver nitrate treatment, since it reaches more deeply lying structures, the tarsus and the upper cul-de-sac.—Dr. W. Galdzieher, Budapest, *Annals of Ophthalmol.*

## ACUTE AND CHRONIC GASTRIC INDIGESTION.

BY

CLARENCE EDWARD BURT, M. D., NEW BEDFORD, MASS.

[Read before the Bureau of Pedology, American Institute of Homoeopathy.]

*Definition:* By gastric indigestion we mean a disturbance of the gastric secretions interfering with the functions of the stomach to such a degree as to cause morbid symptoms. It occurs whenever the stomach is unequal to the task imposed upon it, either because the task is too great or the stomach too weak. A chronic condition develops from frequency of attacks or improper treatment.

*Causes:* In infants the causes are improper food, either poor breast milk or cow's milk containing too high proteins or an excess of fat, sudden weaning, too early use of solid foods or overloading the stomach; in older children indigestible food, overloading the stomach and too hasty mastication.

*Symptoms, Acute:* The symptoms of acute indigestion are vomiting due to irritation of the stomach by the long presence of the undigested mass, accompanied by nausea, eructations of gas and extreme pallor. There is marked prostration, weak pulse and fever. The temperature ranges from 101 degrees to 103 F. and not infrequently higher. Bowels are generally costive. Tongue coated. Distention of the abdomen may be present due to gas. Vomiting causes a depression, which may become very alarming in infants.

*Chronic:* The symptoms of chronic indigestion are much less severe than the acute. The infant vomits generally soon after taking its food, or it may be a long time after, or regurgitation may take place lasting from one feeding to another. This regurgitation consists of a sour, watery fluid and is accompanied by belching of gas and pain in the stomach. In infants especially is the gas most troublesome, as it produces distention and makes the taking of food difficult, so that they can only take a little at a time and want it more frequently. The tongue is usually coated. The systemic symptoms are those of malnutrition, namely, restlessness, fretfulness, loss of weight, disturbed sleep, and constipation or diarrhea. In older children the disease is not as common and presents a somewhat different aspect. The prominent symptoms are



coated tongue, fetid breath, vomiting of mucus, variable appetite, fretfulness. They are also easily fatigued and generally constipated.

*Treatment:* In considering the treatment of acute gastric indigestion we first empty the stomach as completely as possible, then give it absolute rest. I generally wash out the stomach at the start. My method is as described by Holt. A soft rubber catheter, No. 21-25 French scale with a large eye preferred, is attached by means of a glass tube three inches long to another rubber tube, 20 inches long, attached to funnel holding from four to six ounces. The child is held in a sitting posture, head inclined forward with its body protected by a rubber sheet. The catheter, after being moistened with sterile water, is passed rapidly back into the pharynx and on down the esophagus into the stomach. The distance from lips to stomach is about ten inches. When the stomach is reached the funnel is held as high as possible to allow the escape of gas. It is then lowered to siphon out the fluid contents. From three to four ounces of water are poured into the stomach, the funnel then lowered and the water siphoned out. This procedure is repeated until the fluid is returned perfectly clear. I never use any solution, preferring just plain boiled water, and using that at a temperature of from 100 to 110 degrees F. Lavage is generally limited to children under three years of age, since older children become so alarmed that it makes it difficult.

If lavage cannot be employed, the child may be given from the bottle, large amounts of luke warm water, which usually produces vomiting, but this method is not nearly as complete as the washing. Lavage is contraindicated where there is cardiac disease or any pulmonary disturbance.

After the stomach has been washed a high enema should be given to unload the bowel. After this everything should be withheld for three or four hours. The subsequent treatment is chiefly dietetic. After a wait of three hours with little or no vomiting, I gave the infant half an ounce of the following mixture every hour, being sure that it is given cold or very warm:

Mellin's Food, 2 level tablespoonfuls.

Water boiled, then cooled, 8 fluid ounces.

Its composition is fat .00, proteins .60, carbohydrates 4.35, with 6.2 calories per fluid ounce.

Or albumen water, prepared as follows:

White of 1 egg.

Water boiled, then cooled,  $\frac{1}{2}$  pint.

Pinch of salt.

Mixed well and fed cold. One teaspoonful of brandy may be added if you choose, though I do not prefer it. Barley water, too, may be given if preferred.

If vomiting continues I use equal parts of water and lime-water, with Mellin's Food, two level tablespoonfuls.

Starting as I always do on this easily prepared, simple Mellin's Food formula, I am able to add to it as the child builds up, and in the meantime the baby's strength is maintained.

If it happens to be a breast child, I simply withhold its food for twenty-four hours, then gradually return to its nursings, at first allowing it to nurse two minutes every three hours; then increase to three, four, five minutes and so on.

The great mistake made in many of these cases is to begin food too soon and to give too much, especially of cow's milk. Usually cold foods will be retained better than those which are heated. If the food or water is vomited a further rest of the stomach from eight to twelve hours may be ordered before resuming feeding.

The treatment of *chronic* gastric indigestion is merely a repetition of methods used in the *acute*. While in the acute lavage is employed only once, here we find it necessary to be used daily, and sometimes for a long period. There is no one way of feeding these cases. We must first endeavor to determine which of the elements is the chief cause of the trouble. It is generally due to the fat, and authors disagree as to whether or not the proteins or sugar come second. The fat must be reduced, as generally not more than 1.5 per cent. can be taken. Starting as I do in my acute cases with a "no fat" formula, I am generally able to take care of my sugar and proteins so that they do not become troublesome. Right here I must say a word about maltose or malt sugar. It reduces the nitrogenous waste by sparing the body-proteins and I have found it more assimilable and less fermentable than other sugars, enabling the infant to tolerate a greater amount of carbohydrate, thus in the end giving us far better results than obtained with milk sugar. I use Mellin's Food as a maltose solution, since it is unvarying and since the relative amount of maltose to dextrin (approximately, maltose 60 per

cent, dextrin 20 per cent., total carbohydrate 80 per cent.) is such that those carbohydrates can be given without causing either constipation or diarrhea.

Sometimes a change of diet to a farinaceous food is the best way to overcome long continued trouble resulting from failure to properly digest either the fats or proteins. Careful study of the individual child is necessary to be successful.

In addition to the dietary treatment, let us not overlook the general treatment. Plenty of fresh air both night and day. A large, roomy nursery helps a lot. Rubbing the body gently with cocoa-butter is often most beneficial.

Thanks to Hahnemann, we have first and foremost valuable drugs to meet individual symptoms, and of those you must select according to the law of *similia similibus curantur*. A few leaders are ipecac, pulsatilla, nux vomica, graphites, bryonia alba, arsenicum album, hydrastis canadensis, antimonium crudum, and phosphorus.

*References:*

Holt, "Diseases of Infancy and Childhood."

Kerley, "The Treatment of the Diseases of Children."

Rotch, "Pediatrics."

Morse, "Case Histories in Pediatrics."

Blackwood, "Diseases of the Food Tract."

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THE EFFECT OF MEDICATED VAGINAL DOUCHES.—That there is yet much to be explained in the development of disease through the agency of micro-organisms is suggested by the study of Polano. He found that a prolonged reactionary change in the bacterial flora of the vagina cannot be produced by any of the commonly used remedies. A great lessening of the germ content up to almost complete absence of bacteria could be produced by solutions of alum, alcohol, alsol, argentum nitricum, iodine, and from simple tap water, with powdering with bolus alba. Lysoform has but a slight germicidal effect, while acetic acid, lysol, lactic acid, and soda solutions cause an enormous increase of bacteria. The fact that the relatively strong disinfectant, lysol, and lactic acid also, showed so bad an effect, indicates that the effect of vaginal douches is not determined by the bactericidal action of the medicament, the increased acid content of the vagina, nor the augmented bactericidal powers of the vaginal secretion induced by lactic acid, but that the best results are produced especially by purely mechanical properties of the indifferent remedies (tap water) or by drying or by tanning properties of the various remedies.—*Monatschr. f. Geb. u. Gyn.* Vol. 34, 85.



## REPORT OF THE DEAN OF THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL OF PHILADELPHIA.

PRESENTED AT THE ANNUAL MEETING OF THE ALUMNI ASSOCIATION, JUNE 6, 1912.

### FELLOW ALUMNI OF HAHNEMANN:

A review of the second year of the present administration, if tersely put, would spell the word **WORK**. As stated in last year's report this means the work of each and every individual and, what is more, the collective work of one and all—"a long pull, a hard pull and a pull all together." The report this year differs from that of last June in that we then dealt with plans inaugurated and things to be done, while now we can speak of plans perfected and things accomplished; and yet, as should be the case every year, we shall still speak of things to be done.

On taking charge of Hahnemann in July, 1910, we faced the height of the agitation in medical teaching in the United States. Instead of berating the organizations or individuals leading this movement, or impugning their motives, your Faculty realized that it would be out of the question to right the wrongs done our institution by an equal publicity. We, therefore, set to work to obtain an equipment and to build up a curriculum which would meet the requirements of even the hypercritical; to eliminate the student who was not equal to such requirements, as well as the teacher whose teaching was perfunctory or below par. Finally, to insist on preliminary qualifications which would absolutely fulfill the letter of the law in our State, no matter where the candidate proposed to practice. We are now ready to go a step farther and earnestly recommend, until we can require, that each matriculate shall have spent a year in the study of Inorganic and Organic Chemistry, Physics, Biology, Medical Latin and Greek and, perhaps, French or German. This done we shall be able to squarely meet what appears to be the last word of the Council of Education of the American Medical Association and incidentally it may be said that it is a pity that the American Institute of Homoeopathy has not taken an active part in this movement.

So far we are perfectly in accord with the raising of the entrance requirements and we are prepared to give such a pre-

liminary year to any students purposing to enter Hahnemann. We would call your attention, however, to such universities as offer a man an A. B. and an M. D., in full, in seven years and an A. B. with a statement on the diploma that such an A. B. is of inferior grade, together with an M. D., in six years. The trend of such a system should be self-evident to every one of our Alumni.

As stated in the last report, our first changes were directed toward the superstructure, the Hospital and Dispensary teaching—where the equipment and the material were ready. This year we have turned our energies to the fundamentals and as a result we are eliminating the “unworthies” from the very start. We have advised several first year men to give up the study of medicine after watching their work for a few weeks, although their entrance requirements were up to par. A man who is not a student in the full sense of the term is eliminated in the first year. If he is found to be a fit candidate for the second year preliminary examinations, he is recommended to the State Board of Examiners. If during his third, or clinico-didactic and laboratory year, he shows that he is competent to study medicine, we are ready to make out his diploma, to be signed a year later. With the new regime we shall have no fourth year failures, no State Board failures, either at the end of the second or fourth years, and no conditions after the first and second years. What is more, we shall be turning out a type of man you will be proud to receive as colleagues and as members of this Alumni Association.

This brings us to the changes in the college, accomplished and prospective. The Laboratory of Physiology has been built, equipped and tested out by a successful year's trial. The same can be said of the Laboratory of Pharmacy and Chemistry where excellent work has been done under the direction of the teachers in these departments. The Library and Reading Room can best be referred to by asking your inspection of the same and by telling you of their constant use by the student body and by the College and Hospital Staff. We have raised and expended \$6,000 or more for this Library which contains, on the main floor, some 8,000 volumes of the latest, up-to-date, medical works, together with files of thirty or more medical journals. The books have been cross indexed by the card system, subjects and authors, and are readily accessible, day or evening, and the same applies to the Reference Library in the

basement of 8,000 volumes or more. Dr. Weaver's new Museum is also an accomplished fact and requires but your inspection to assure you that the change has been a success. The Constantine Hering Laboratory has been doing work which has received well deserved notice both from the medical and lay press. The generous endowment of Mr. Walter E. Hering amply assures its permanency.

As to the prospective college changes, we are now raising \$15,000 to follow suit with No. 3 Lecture Room, which will give us, on the lower floor, a lecture room with a seating capacity of about 100 and a class room for "around-table" teaching, conferences and demonstrations, and, on the upper floor, a large students' Laboratory of Bacteriology and Pathology, accommodating 100 or more. This will free the present Laboratory of Pathology for research work and give us the Laboratory built from the gallery of the old Museum for operative surgery, bandaging, etc. What money is left can be well applied to minor improvements.

In the very important matter of endowment we can report progress also, for during the past two years we have raised the sum of two hundred thousand dollars for this purpose. The question of endowment for a medical school is a peculiarly difficult one. Doctors are not proverbially rich, rather the contrary, and our Alumni in their different towns and cities have their own hospitals and charities to work for. Philadelphians will take care of our Hospital and our Dispensary, just as your fellow-townsmen will support your institutions. We will attend to buildings and equipment, but it is up to all of our Alumni to help swell the "Foundation Fund" which will enable us to carry out the perfected curriculum and keep Hahnemann among the colleges of the first class.

What seemed at first a hardship was the requirement by the Board of Regents of New York for six, full-time, salaried teachers. We have met this, however, and have now on our roll seven such men and with these men spending the bulk of their time in and about the college building, we shall inaugurate, and shall later enlarge, the preceptorial system which is considered so valuable an asset in a teaching institution.

We are so frequently told by our Alumni that they are unacquainted with the details of our curriculum that I shall take the liberty of going over the same in some detail. Among the changes made in the first two or fundamental years are the following:



Dr. Pearson has given a most thorough course in Inorganic and Organic Chemistry, fifteen weeks and eighteen hours a week, during the first half of the Freshman year. This was followed by a laboratory course, fifteen weeks and twelve hours a week, in Physiological Chemistry, paralleling Dr. Belville's lectures during the second half of the year. During the second half of the Sophomore year, Dr. Pearson takes up Toxicology, with lectures and laboratory, for some sixty odd hours and, besides, gives each member of the class thirty-six hours of practice in urinalysis with specimens supplied by the Hospital.

Bearing in mind that Hahnemann owes its identity to the fact that it teaches Homœopathy, the new matriculate begins at once the study of the Principles of Homœopathy. Dr. Nesbit holds weekly conferences in the Hering Research Laboratory throughout the Freshman year, explaining the Organon and instructing them in the reasons for their faith. Along with these conferences they are obliged to do collateral reading and are quizzed on the same.

Mr. Borneman, an experienced pharmacist, instructs the Freshmen two mornings a week during the second half of the year on the compounding of drugs, the different officinal preparations, as well as the details of pharmaceutical technique. This course is supported by the instruction in medical Latin and Greek by Dr. Campbell during the first half of the year and supplemented by practical work in the hospital pharmacy during the dispensary hours in the third year, each student putting up prescriptions, dispensing medicines, etc., under the supervision of the corporation pharmacist.

Another addition has been the course in Pharmacology by Dr. Frosch during the second year, dealing with the physiological action of drugs, dosage, incompatibles, prescription writing, etc. With a parallel course in Homœopathic Pharmacodynamics we feel the student should be ready for the theoretical and clinical study of *Materia Medica* and Therapeutics during the third and fourth years.

The course in Microscopic Technique, Histology, Embryology and Neuro-Histology by Drs. Muhly and Steinhilber has been amplified and runs throughout the first year (about 300 hours). This gives a splendid foundation for subsequent work in Bacteriology, General and Special Pathology and the Clinical Laboratory. The same is true of the course in Biological

Physiology by Drs. Belville and Widman which follows that in Physiological Chemistry and is continued throughout the second year.

Realizing the importance of Hygiene and Preventive Medicine which has now become a State Board subject in the primary class, we have been fortunate in obtaining the services of Dr. Horn, an expert sanitary engineer and a teacher of large experience. His lectures and demonstrations have aroused both interest and enthusiasm among the members of the Sophomore class during the year.

To our anatomical staff we have added Dr. Clemmer, who will give Dr. Weaver much needed assistance in the dissecting room and to the first and second year students, laboratory drill, demonstrations and recitations. To the course in dissecting in the second year we have added demonstrations by the different specialists on their respective subjects, such as the brain, eye, ear, nose and throat, chest, abdomen and the genito-urinary and female reproductive organs.

Perhaps the strongest feature of this fundamental teaching is the time given to frequent and systematic quizzes and reviews which serve to fix the mass of acquired facts in the student's mind and necessitates constant collateral reading to keep up with them.

During the second half of Sophomore year we begin the elementary work in medicine and surgery. Drs. McEldowney and Bullock have devoted some sixty hours to normal physical diagnosis, the recognition of the various lung and heart sounds and of the different viscera in health. For surgery, aside from the instruction in the time-honored bandages, fixed dressings and splints, Dr. Bigler has inaugurated a course in technique which will prepare the student for his work in the dispensary and wards. They are taught how to prepare the operating room and the bed room, even to making the bed; the various enemata and how to give them; the sterilization of the different materials used; the names of instruments and their uses; sutures and ligatures and how prepared and applied; drainage of wounds, hæmostasis, shock and collapse, hypodermo- and entero-clysis, infusion, hypodermic medication, etc., etc.

With the student well grounded in the fundamentals, he is now ready for the Theory and Practice of Medicine, Surgery and the Specialties. In the Junior year four mornings a week, the first semester, and one afternoon, through the entire term,

are spent in the Pathological Laboratory. The teachers who have elaborated this course deserve the highest praise and the plan of work more than a passing mention. After a thorough drill during the second year in Bacteriology, General and Medical Pathology, Dr. Sappington and his assistants take up what is termed Clinical Pathology, or instruction in blood work, urinary sediments, examination of fæces and sputum, serological tests and Clinical Bacteriology. Then comes Special Pathology, such as Surgical Pathology by Dr. Elliott, the Pathology of Obstetrics and Gynecology by Dr. Betts, of the Nervous System by Dr. Fox and of the Eye by Dr. Nagle. The same mornings during the second semester are devoted to Operative Surgery and Practical Obstetrics. Every Wednesday the class sees and performs autopsies and, in contrast with former years, they attend in all about a dozen didactic and three clinical lectures each week during the year.

The individual and sectional clinical work for the two upper classes has been decidedly increased by doubling the dispensary service which extends from one to three-thirty in the afternoon. A considerable portion of the didactic teaching has been changed to sectional conferences, where the subject is gone over with the teacher and students at close range—the preceptorial system again—an hour of talk, explanation or review, with illustrations or presentation of cases and then an hour or more of individual observation and treatment of patients. During this year, Orthopedics, Venereal, Anæsthesia, Radiography, Hernia and Operative Gynecology are taught in this way, while each student treats the patients in the surgical, orthopedic and genito-urinary dispensaries during the associated periods. Diagnosis is continued during this year by a sectional drill, thirty hours per man, in the physical signs as found in the sick, the wards and dispensary affording plenty of material for the purpose. At the same time, the students receive systematic instruction in the taking of case histories to fit them for their subsequent work in the wards.

The same plan is followed in the out-patient work of the fourth year student who spends five weeks each in the Medical, the Neurological, the Gynecological and the Skin dispensaries, and attends forty conferences in Pediatrics, Dermatology and Stomach Diseases.

The instruction in the Department of Laryngology, Rhinology, Ophthalmology and Otology extends over the two years.



the first consisting of forty hours of preceptorial teaching and technical drill in the instruments and the normal organs, and the second, fifty hours of personal study and treatment of patients.

The subdivision of subjects into five and ten week periods, with examinations on the work of each, tends, not only to make the student keep up with his work, but relieves him of the multiplicity of examinations at the end of the year. We are gradually applying this system to the entire course of study, limiting the final examinations to the essentials or so-called *major* subjects.

The work of our fourth year has been referred to quite fully in last year's report, our chief concern this year having been that of adjustment and the development of teachers. Briefly, the senior student attends five didactic and five clinical lectures each week, together with an hour's teaching in one of our associated hospitals, the Children's, St. Luke's, or the West Philadelphia General Homœopathic. Aside from this his entire time is spent in the Hospital and Dispensary. The latter has been explained and the Hospital work is divided into three periods of ten weeks each, as follows:

1. Medicine, Therapeutics and Neurology, morning and afternoon (265 hours); bedside study, "ward walks" and conferences. Each case is assigned to a student who takes the history, makes all clinical examinations and prepares himself to present the same at the conference. During the "ward walk" the teacher goes over the different cases with the section. Nearly one-third of this entire time is devoted exclusively to the study of the homœopathic prescription.

2. Surgery (190 hours). The cases are similarly assigned, studied and discussed in the "ward walks" or conferences. When operations are performed, the student in charge assists, another one anæsthetizes and the operator then dictates the work done to complete the history.

3. Obstetrics and Gynecology (180 hours), on very much the same lines as the two preceding departments. Two students attend each confinement and two examine each patient operated in either department.

The Walter E. Hering Clinical Laboratory has been an invaluable aid in this work, each man having his desk and free access for the study of his problems at any time. It is surprising to find how much practical experience a student has ac-

quired during the year, a comparison of the ward work of the individual and the section during the first and third periods being most striking. To get some estimate of the amount of practical work actually done by each man, every student in the college has been requested to keep a diary throughout his entire course and from the rather meagre data so far available, it is evident that our students will surpass by far the proposed requirements of the Bureau of Medical Education of this and other States, to say nothing of a comparison with other institutions.

In conclusion, permit me to add that we have not forgotten the subject of Post Graduate study. After testing our plan for two years and after consulting the physicians who have worked with us, we are of the opinion that such work can best be done during the college term and not as an aftermath of the session, nor as a special course in the summer. As stated last year, the physician can send an outline of what he wants and a roster will be made out for him, periods of five or ten weeks, or multiples of the same being preferable.

To sum up, Fellow Alumni, we have amalgamated College, Hospital and Dispensary, so that each one is as much "College," so far as teaching is concerned, as the other.

We have raised an endowment of two hundred thousand dollars and as all the finances are in the hands of our Trustees, the institution is managed by experienced business men on sound business principles.

We have changed our entire curriculum to conform with that of the most advanced medical schools in the country.

We have added to the equipment of the College, Hospital and Dispensary by Library and Reading Room, new Laboratories and Class Rooms which enable us to carry out this new curriculum.

We have enforced the preliminary requirements in the spirit as well as in the letter of the law and we propose to increase the same.

We have raised the standard to a point where a student should be safe with any State Board and what is better still, where he will satisfy us that he is worthy of our noble profession.

We have been thoroughly and critically inspected and have received the hearty approval of the Board of Medical Education and Licensure of Pennsylvania and we have demonstrated

to its members that we not only can comply with all their requirements for practical work, but can excel any medical school in the State in this respect.

If you approve of our administration, support us by word and deed, increase our endowment and send us students, but send us men who are worthy of Hahnemann and Homœopathy.

Respectfully submitted,

WM. B. VAN LENNEP.

*Dean.*

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SOME NEWER VIEWS OF ECLAMPSIA.—The tendency lately to make a critical review of the deductions based upon statistical observations of several important diseases has been recognized by Lichtenstein and applied to eclampsia. The interpretation of statistics has led to the acceptance of certain methods of treatment not always justifiable, and the matter is of importance on this account. Lichtenstein's article touches not alone upon this phase of the subject, but reviews the whole subject of eclampsia as expressed in the experiences during ten years at Zweifel's clinic in Leipzig. Among his deductions are that the statistics of eclampsia as heretofore compiled are faulty in that they do not take sufficient account of cases occurring during the puerperium. These cases are really to be reckoned as early deliveries and are to be compared with those having had one or two attacks and with those having had three or more convulsions. According to the new statistics in cases of early delivery, that is before the first or after the second convulsion, the latter cease in one-fourth of the cases. When the percentage is based upon all cases of eclampsia it develops that in only one-third do the convulsions cease after delivery, and not in 50 per cent. or even in 80 per cent. or 90 per cent., as the old form of statistics seemed to indicate. The author has found that the mortality among cases during the puerperium is really unusually high, and that the mortality after early delivery is not materially better than after rapid delivery, and in both is about the same as the total mortality. There is, however, a greater difference among the variously delivered eclamptics and this depends upon the amount of the blood loss. This important fact is demonstrated in various ways by the author. He has shown that in those cases where the convulsions have ceased after delivery the blood loss was half again more than in those where the attacks did not cease, and was four times more than in those where the eclampsia first appeared in the puerperium. From this it is concluded that the results of early and of rapid delivery do not depend upon emptying the uterus, but upon the amount of the blood loss. This fact is further emphasized by the good results of vivisection in eclampsia in puerperæ.—*Arch. f. Gyn.* Vol. 95, 183.



## EDITORIAL

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### THE PRESENT STATUS OF MEDICAL EDUCATION IN THE UNITED STATES.

DURING the past five years the status of medical education in the United States has received widespread attention both on the part of the members of the profession and of the public at large.

The low standard that previously prevailed in the average American medical school was notorious, many institutions being conducted more with a view to paying large dividends than for the purpose of giving their students an adequate medical education.

Owing to the comparatively small amount of capital necessary to inaugurate the so-called medical college of a decade or two ago, the number of such institutions conducted for profit steadily increased until 1904, when a maximum number of one hundred and sixty-six colleges was reached.

About 1905, through the co-operation of state examining boards and committees representing various medical bodies, efforts were instituted to raise the entrance requirements to medical schools and to insist that all institutions granting the degree of Doctor of Medicine should be adequately equipped to give a practical medical training.

During the years 1908, '09, and '10 the Carnegie Foundation began its inspection of the medical schools in the United States and Canada. Mr. Abraham Flexner, representing this Foundation, visited all of the medical schools of these two countries and gathered together such data relating to them as he could obtain. His report, published about two years ago, was far from being complete and by no means free from prejudice; but taken as a whole it conveyed a fair idea of the state of the American medical institutions as they were then conducted. The criticisms made upon the medical colleges in this report and the wide publicity that was given to them through the medium of the daily papers, excited a great deal of atten-

tion on the part of the laity, and a loud demand for improvement in medical training arose from all sides.

Without attempting to pass judgment on the report of Mr. Flexner, it must be freely admitted that the practical outcome of his report was to stimulate renewed activity in the various medical schools, and the results that have followed have been of advantage both to the profession and to the public.

During the past seven years there has been a rapid decrease in the number of medical institutions. Approximately forty-six colleges have closed their doors, so that at the present time there are about one hundred and twenty medical colleges in active operation in the United States. During the same period of time there has been a marked diminution in the number of medical students, there being approximately six thousand less medical students in the colleges as compared with seven years ago.

Probably the most radical changes brought about by the recent agitations have been those relating to the amount of practical work in the laboratory and at the bedside that it is insisted upon the student shall do during his college course. In the majority of American medical schools, the teaching has been purely of a didactic nature, and the larger proportion of students who receive their degrees have had little or no experience personally with actual cases of disease.

The institution of bedside methods of teaching, in contrast to the didactic system, necessitates large hospital facilities in connection with the medical schools. It is in this particular that many medical schools are weak and their closure in many instances has been due to their inability to secure sufficient hospital facilities to carry out the newer methods of instruction. It is with feelings of satisfaction that the members of the homœopathic profession can point to the fact that a number of the homœopathic colleges are very adequately equipped in this respect. As Dr. William B. Van Lennep has pointed out in "The Annual Report of the Dean of the Hahnemann Medical College of Philadelphia," that institution has entirely remodelled its course during the past two years in accordance with the newer requirements and, to-day, is giving a course of medical instruction far superior to the courses given to the vast majority of old school colleges. In fact, it is a question whether any other medical college of Pennsylvania will be able

to reach the standard set by Hahnemann Medical College in this respect.

The next important step in the improvement of medical teaching will undoubtedly be to raise the standard of preliminary requirements for students desiring to enter upon the study of medicine. Many institutions have been notoriously lax in this respect, and, in their desire to increase the number of their student body, have admitted practically every student who has applied. Fortunately, however, such action has met with vigorous condemnation on the part of the profession and is being steadily but reluctantly abandoned.

The overcrowded ranks of the profession and the large percentage of physicians who are barely able to eke out an existence, have convinced every serious student of this problem that the demand to-day is not for more doctors but for better doctors. It is to this end that the efforts of the profession should be directed and those who desire to aid the cause of homœopathy and to assist in the up-building of homœopathic medical schools can do no better than to send as their students young men whose preliminary education and whose intellectual acquirements are such as will enable them to become competent and reputable physicians who will reflect credit and honor upon the homœopathic profession.

G. H. W.

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### OBESITY.

THE study and treatment of obesity has always attracted the attention of medical men both from a scientific and practical standpoint. The vast majority of patients who suffer from an excess of fat, endeavor at some time or other to restrict their diet or to make such other changes in their habits as they believe will tend to reduce their weight. The vast majority of these efforts, however, are a failure, either because the method employed is not suited to the particular case, or because the patient grows tired of the treatment within a very short time.

It has been our observation that the majority of physicians have but little confidence in the so-called dietetic cures and are inclined to give but little serious thought to the treatment of the average case of obesity. There is no doubt, however,



but that a great deal can be done in a large proportion of these cases to reduce the superfluous fat, provided the physician is willing to study the case thoroughly from an etiologic standpoint and the patient is willing to persist sufficiently long in the course of treatment outlined to enable the physician to determine definitely the effects that are being obtained.

The work of von Noorden, in his studies of nutrition, has done a great deal to put the treatment of obesity on a practical basis. He divides these cases into two main types, first, the exogenous, in which the obesity results either from over-eating or from insufficient exercise; second, the endogenous, in which the condition arises from some disturbance of metabolism, presumably dependent upon some abnormality in the internal secretions. In the practical management of these cases it becomes important to determine if possible to which of these classes the individual case belongs, as the treatment must be largely based upon the decision on this point.

The exogenous cases are usually benefited by a reduction in the diet and by the institution of proper exercise.

The endogenous cases as a rule are but little affected by dietetic measures and are usually more or less difficult to manage. In this group of cases, the secretions of the thyroid gland and of the pituitary body seem to be most frequently at fault. It is possible that the pineal gland, the thymus, the adrenals and the pancreas may also be a factor in some cases. Contrary to the prevailing opinion, experimental evidence would seem to indicate that the ovaries and the testicles exert no apparent influence on obesity.

The past history of the individual must generally guide us in arriving at a correct diagnosis of the causative factor. In many cases we get a definite history of over-eating or of insufficient exercise. On the other hand, in the endogenous cases, we may find that the amount of food consumed by the patient is very small. Symptoms indicative of disturbed action of the thyroid, of the adrenals or of some of the other glands of internal secretion may be present. If there is doubt as to the cause it is a wise rule clinically to place the patient on a strict diet for two or more weeks and, if little or no loss of weight occurs, it is probable that the case is of the endogenous type.

A great variety of dietetic measures have been devised for the management of cases of obesity but it is probable that the factor in them all that is of therapeutic value is the reduction

of the food in general. The majority of authorities insist upon a decided reduction in the intake of carbo-hydrates and fats. Recently a number of writers have advocated a diet of milk and vegetables. The reduction of the amount of water ingested by the patient seems to be a factor of importance. In many instances hot baths and electric light baths followed by exercise and massage are also of value. Thyroid extract has given excellent results in some cases, especially where the obesity is of endogenous origin. Wagner advises that this treatment should be kept up for from three to five weeks in combination with a restricted diet.

During the administration of thyroid extract a close watch should be kept for tremor, dizziness, ringing in the ears or palpitation of the heart and, upon the onset of such a group of symptoms, the use of the extract should be temporarily abandoned.

G. H. W.

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HAEMOLYTIC STREPTOCOCCI.—Lamars (Halle) has endeavored to determine the facts concerning hæmolytic streptococci in the vaginal secretion, a matter which has acquired importance as related to puerperal auto-infection. He has found that hæmolytic streptococci occur in the genitalia of pregnant women. This occurrence, however, is not constant, but exceptional. In the lochia their existence cannot be explained by the multiplication of those already existing during pregnancy. Neither do they exist there from having been introduced during labor by internal examination. Neither do hæmolytic germs in the puerperium develop from those ascending from the external genitalia during delivery or during the puerperium. Their presence in the lochia is not ascribable to transportation of germs from one woman to the other. But in the pregnant, parturient and puerperal women there are found weakly hæmolytic colonies, often coloring the blood plates greenish, which are to be regarded as transition forms between an hæmolytic and hæmolytic streptococci. From the author's extensive examinations it has appeared quite probable that hæmolytic streptococci may develop from an hæmolytic forms. The hæmolytic streptococci which without symptoms are found in afebrile cases have developed from an hæmolytic germs. Those which cause symptoms in puerperæ are streptococci foreign to the patient and formerly or recently introduced from without. The hæmolysis of streptococci does not indicate their pathogenicity, but is only the evidence of better conditions of growth. It is urgently required to seek further for a test to determine the indifferent or pathogenic character of hæmolytic streptococci in a given patient.—*Arch. f. Gyn.* Vol. 95, 74.

## GLEANINGS

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THE CURE OF ECLAMPSIA.—In the *British Medical Journal* of October 2, 1911, Tweedy insists that all toxemic patients should be treated as eclamptic, even though they have not developed fits. The lateral position must be insisted on for the removal from the throat of mucus. Inhalation of oxygen and artificial respiration should be undertaken whenever the patient shows any sign of respiratory obstruction. Food of any kind is deleterious, and should be withheld for long periods after consciousness is regained.

On admission his patients were given one-half grain of morphine hypodermically; the stomach was washed out, and a purgative poured through the tube. There is no importance attached to the nature of the purgative; it must be efficient.

Formerly one to one and a half pints of fluid were left in the stomach, but this has been omitted latterly, as occasionally it was found to regurgitate into the mouth, and the plan was also open to the fear that by its weight and position the fluid might embarrass the heart. After the stomach is washed out the catheter is passed and the urine withdrawn, measured, and examined. The patient is then turned on her side, and the rectum and lower bowel thoroughly washed out with solution of sodium bicarbonate through a long rubber tube. If an enema has been given immediately on admission it will have some effect in softening fecal masses, and will probably make subsequent rectal washing more effective. Lavage must be very thorough; a pint to a pint and a half of fluid is used at a time, and the procedure continued till a large amount of fecal matter has been washed out. Gallons of water may have to be used before these masses are sufficiently softened. When once the bowel is cleared one to one and a half pints of a solution of sodium bicarbonate (one-half drachm to a pint) is left in the rectum.

If in spite of this the urine remains scanty, submammary infusion of a similar solution is practiced; these injections may amount to from one to two pints.

Saline solution was formerly employed for the purpose, but the fear that salt would add to the difficulty of elimination caused the substitution of plain water, which in turn was finally discarded, because of the theoretical fear that laking of the blood would result. Linseed-meal poultices to the loins help to increase renal activity; they are to be changed every three hours. Mucus that forms in the mouth falls into the cheek and is to be wiped out with moist cotton-wool. It is a great mistake to wipe mucus from the pharynx, particularly when it requires the introduction of a gag. Such manipulation irritates the patient to quite an unnecessary degree, and is one of the many causes of spasmodic choking.



Tweedy says it is a grave error in treatment to leave the patient in the charge of one or two inexperienced nurses. They cannot be trusted or even expected to take the initiative in resorting to measures to restore an asphyxiated patient. A medical man should always be in attendance. This is frequently a difficulty, but must not be considered an impossibility by those who realize its importance. If mucus forms in the throat and spasm of the glottis occurs, the attendant is instructed to draw the patient's head and shoulders over the side of the bed and at the same time to turn the face down toward the floor. This can be facilitated by grasping the hair. It is immediately followed by an outpouring of bloody mucus from the nose and mouth, with rapid relief of symptoms. Oxygen and artificial respiration are important aids in the re-establishment of breathing.

The patient is disturbed as little as possible for twelve hours, although if the bowels have not moved treatment is persisted in every eight hours to effect this. The catheter, too, is passed every eight hours. Morphine, beginning with one-half grain doses and followed by one-fourth grain doses every two hours, is given whilst the fits persist until two grains have been administered within twenty-four hours. At times doses as moderate as these produce surprising slowness of the respirations. When they fall to six or seven per minute it is an indication that enough morphine has been given. Atropine or scopolamine may with advantage be substituted, together with artificial respiration. Should consciousness be restored sufficiently to permit of swallowing, the patient is encouraged to take frequent draughts of hot or cold water, but until recovery is complete all forms of nourishment should be withheld.

As to the lines of treatment to be avoided:

Accouchement force comes first. Many patients recovered from eclampsia and carried their children for considerable periods afterward. While labor occurring during the seizures is not pleasant, yet should it do so, the os rapidly dilates. When fully dilated, delivery may be expedited with forceps, but as a matter of fact the application of forceps is seldom found necessary. Delivery is usually easy, and there is considerable difficulty in conducting an aseptic artificial delivery in these cases; for this reason, if for no other, spontaneous delivery is preferable. A patient should not be permitted to die undelivered, and if death threatens, vaginal Cæsarian section should be performed.—*Therap. Gazette.*

THE END RESULTS OF OPERATIONS ON THE STOMACH AND DUODENUM.—Short publishes his conclusions drawn from a study of the records of all the stomach cases treated in the wards of the Royal Bristol Infirmary during the years 1902 to 1910 inclusive. The number of patients under consideration is 165, of whom 60 died, 30 were lost sight of, leaving 75 to be investigated. The great majority of these cases have a history extending over seven years since they left the infirmary. The outstanding feature of the whole study is the demonstration of the extraordinary value of gastrointestinal short-circuiting for ulcer of the stomach or duodenum.

Another remarkable feature in this study is the occurrence of so many cases diagnosed clinically as gastric ulcer, but presenting no signs of the condition on the operation table. This relates not only to five patients with

severe hematemesis, but also to a dozen others, whose symptoms had been indistinguishable from those of genuine organic trouble. In two of them the stomach was notably dilated. The author naively remarks that an inaccurate diagnosis makes no difference, because in these cases a gastrojejunostomy usually brings relief.

A third point of interest is the association of gastric ulcer, or symptoms of gastric ulcer, with movable kidney. It is noted that in one case the kidney was fixed twice without relief before the girl was finally cured by gastrojejunostomy. In another a patient two years after kidney fixation was admitted dying of perforated gastric ulcer. In the third case the nephrorrhaphy was completely successful for years, and then a gastric ulcer formed. Of the perforated gastric or duodenal ulcer there were 61 cases. In two no operation was performed, in one instance because diagnosis was not formulated, and in another instance because the patient was ready to die. In one the ulcer could not be found after prolonged search. These three cases all died. Of the remaining 58 ulcers closed by operation 26 died. There were 12 cases between seventeen and twenty years of age, and comparatively few after the age of forty. Of gastric pyloric cases 22 were males and 26 females; of duodenal cases four were males and two were females. Of the recovered patients 23 have been followed and 10 lost sight of. In these 23 two had a primary gastrojejunostomy performed and were absolutely cured and can eat anything without trouble. Two had the ulcer excised and the incision sewn up like a pyloroplasty. One is completely cured and the other improved.

Of the remaining 19 only four expressed themselves as entirely well; two of these came in again for gastrojejunostomy. One of these was cured and the other improved. It is noted that in 85 per cent. of the cases of perforating ulcer, the ulcer is not at the pylorus. In 52 per cent. of the cases that come to operation for dyspepsia the ulcer is at the pylorus. Early operation, within twelve hours of perforation, saves about 80 per cent. of the patients. Later operation is usually unavailing, but the results do not get very bad until the second day. The figures speak decidedly against lavage of the intestines. Nearly all the sufferers continue to complain of indigestion afterward, unless gastrojejunostomy be performed at the same time.

Of cancer of the stomach there were 33 cases, including 25 men and 8 women. The ages varied from thirty-nine to seventy-one, the great majority being between forty-eight and sixty.

Only in four patients was there a history of gastric troubles eighteen months in duration; usually the symptoms had come on within less than a year. Pain was always present, vomiting was usual, and anorexia and wasting were usually noted. Only three patients vomited blood, and in one of these it was eighteen months before admission. Obvious or occult blood in the stools was much commoner. In 20 cases the abdomen was explored and closed again. Of these seven patients left the infirmary and were lost sight of. Five others died within a month. No deaths seem to have been hastened by the operative intervention. Only one individual lived for more than four months; he survived for more than two and a half years with a huge tumor, which proved to be inoperable on the second attempt, after which he died. In eight cases gastrojejunostomy was performed. Two died

of the operation within a few days. One patient not relieved was lost sight of. In the other five some had transient comfort. In four patients extensive resections were performed. Two died of shock within a few days.

Of the 41 cases of gastric or pyloric ulcer, 20 patients out of 29 followed through were absolutely and perfectly cured and could take any ordinary food following gastrojejunostomy. There were no deaths from the operation.—*Therapeutic Gazette*.

CONSERVATIVE TREATMENT OF ANEURYSMS AND HEMATOMATA.—C. Monod and J. Vanverts state that the surgical treatment of aneurysms includes extirpation, incision, or obliteration of the sac. For aneurysms of the neck and limbs the proportion of cures is 74 per cent. for ligature, 80 per cent. for incision, 90 per cent. for obliteration, and 89 per cent. for aneurysmorrhaphy. After careful consideration of the different methods of operation and their results the authors give the following conclusions: conservative operations are characterized by a considerable number of successes and an almost complete absence of gangrene; but recurrences and post-operative hemorrhages are somewhat frequent, due to insufficiently solid union of the vessel walls. The artery generally remains permeable immediately after the operation. After some days this permeability seems to disappear in a considerable number of cases; but this secondary thrombosis has few inconveniences, since the collateral circulation has been established before arterial obstruction became complete. Arterial lesions of traumatic origin are easier to treat than others because of the less friable condition of the arterial walls.—*Revue de Chirurgie*.

IVY POISONING.—Dermatitis venenata, always very unpleasant and occasionally dangerous, presents as long a list of possible medicaments as is claimed for pertussis or pneumonia.

Recent studies have demonstrated the cause of the irritation and it is now known that the irritating agent may be neutralized by permanganate of potash solution. The application of the permanganate solution gives great relief and when used soon after exposure or as soon as the first vesicles appear will avert the distressing itching. Treatment should be as follows: First thoroughly wash the part or parts with warm water and soap; then use an alkaline wash, as for example a teaspoonful of bicarbonate of soda to one pint of water. Following this should come several washings in warm 2 per cent. to 4 per cent. solution of permanganate of potash. The strength of the permanganate solution should vary according to the severity of the attack.—*Med. Review of Reviews*.

DIFFERENTIATING URETHRAL SHREDS IN ANTERIOR AND POSTERIOR URETHRITIS.—Wolff (*N. W. Univ. Bul.* Vol. XIII, No. 2), describes a unique method of staining urethral shreds in situ as used in Dr. Von Frisch's clinic, the Polyclinic Hospital, Vienna. The method is as follows: 1 c.c. of a 0.5 per cent. solution of basic fuchsin in distilled water is slowly injected into the anterior urethra and retained for thirty to sixty seconds during which time slight massage is practiced. The fluid is now allowed to escape. The patient urinates into two glasses. All of the anterior urethral shreds are stained a deep red color. If there are only red stained shreds present, their localization is obviously the anterior urethra. If, on



the other hand, only white or unstained shreds be present, the infection is in the posterior urethra. These latter unstained shreds may show in both glasses, as the contents of the entire urethra are washed into the first glass. The stained shreds, however, are always from the anterior urethra. When both stained and unstained shreds are present, the localization is both anterior and posterior.

He states that the essential value of this test arises from the fact that as the first glass generally contains the entire urethral contents, posterior urethritis cannot always be excluded when the second glass is clear using the ordinary two glass test so generally employed. The differentiation of the shreds from the anterior urethra overcomes the previous existent diagnostic difficulty.—*Med. Review of Reviews.*

THE TONIC EFFECT OF CANE SUGAR ON DEBILITATED HEART.—Physiologists teach us that wherever found—in the muscles, in the placenta, or elsewhere—glycogen is a source of carbohydrate material, which may be oxidized into dextrose. Also, that during life, glycogen is converted into dextrose by the agency of a ferment, likewise formed in the liver, and that the resulting dextrose is conveyed away in the blood of the hepatic veins, to be consumed in supplying the muscles with energy and to maintain animal heat. An experiment by F. S. Locke (King's College, London) proves that dextrose is capable of nourishing the heart muscle in a wonderful and peculiar manner. He kept an excised mammalian heart beating for ninety-one hours after the death of the animal from which the heart had been taken. Perfusion with a solution of dextrose was carried on daily for five days, and, at the end of that time, the heart was beating so regularly that it was used by Professor Halliburton to demonstrate to a class of students.

From this paper we learn that, owing to the extraordinary effect of dextrose, in keeping up the pulsations of an excised mammalian heart, Dr. Goulston was induced to try it as a remedy in heart disease, to strengthen and regulate the disordered movements of debilitated human hearts. He tried it in several cases, using it in the form of Glebe granulated sugar, which is said to be one of the purest cane sugars on the market. He mentions its successful use in two cases of the dilated heart of advanced age; in two cases of valvular heart disease; in a case of post-influenzal dilatation of the heart; in a case of heart strain; in a case of heart failure in tuberculous phthisis; in anemic cases with dilated hearts, and also in a case of chloroform heart.

Owing to the clearness and cogency of the observations made by Drs. Goulston and Carter, their cases deserve close study. Of course, every doctor, and a good many people who are not doctors, know that cane sugar has large nutritive value. May not the instinctive devotion to tea, which is manifested by some persons, be largely due to the nutritive effect produced by the taking of three ounces of cane sugar, daily, to sweeten their tea? Probably this is the case. Hunters, soldiers making forced marches, laborers engaged in heavy work use granulated sugar with advantage. The beneficial influence of a lump of sugar eaten occasionally, in keeping up strength and preventing exhaustion after hard work is due to the nutritive effects of cane sugar on the muscles. When the heart is

overcome by fatigue from any cause, it is relieved and nourished by the ingestion of cane sugar. The medicinal use of cane sugar by persons who have dilated hearts, or even valvular disease of the heart, is an extension of the same notion.—*J. J. C. in Canadian Journal of Medicine and Surgery.*

THE INFLUENCE OF SODIUM CHLORIDE UPON THE HYDROCHLORIC ACID OF THE GASTRIC JUICE.—(Samuel Floersheim, M. D.) Statements are current that sodium chloride instilled into the human economy acts as a factor in increasing the production of hydrochloric acid in the stomach. Abstinence from salt would therefore be followed by a material diminution of the hydrochloric acid in the gastric juice while inhibition of it would be followed by increased acidity. It is a generally accepted fact that the hydrochloric acid is derived from the chlorides in the blood circulating in the stomach mucosa. It need not necessarily be the sodium salt that is required, but it is the most serviceable, readily attainable, and easily transformed. If this assumption is correct we should have a method of treatment for increased or decreased HCl acidity of the gastric fluid which would commend itself for its simplicity, its adaptability, and its cheapness.

Again, in excessive HCl acid, with or without excess of fluid secretion, the most potent, universal, cheap, and efficient remedy, sodium bicarbonate, is an excellent temporary measure. In a number of cases (without carefully searching for the etiology) a cure is effected. In administering the bicarbonate of soda as an antidote we, at the time, according to the above statement, place within the affected area the exciting cause that is believed to bring on this very condition which we are attempting to cure or relieve.

For the past few months experiments have been undertaken to determine the influence upon the HCl of sodium chloride when taken in the stomach by mouth; in the rectum, by proctoclysis. From a number of patients, eight were taken for experimental purposes, four in whom the free HCl of the gastric contents registered persistently above 80 degrees and four in whom the free HCl was observed to be constantly below 15 degrees. In the hyperacid cases salt was omitted from the diet while in the hypoacids it was allowed to be taken by mouth and a number of times by proctoclysis. No other form of treatment was instituted and the usual mode of living was advised.

In the beginning of the experiments each patient was properly prepared for the ordeal. The usual Ewald test meal was given and routinely examined every fourth day. Five tests were made in each subject. It was constantly noted that in the excess HCl secretion there was no appreciable diminution of the acid content in the aggregate (variations with each test meal were observed); likewise in the low free acid cases there was no conclusive or sharp increase of free HCl secretion.

The reverse experiments were then undertaken, *i. e.*, salt and salines in the cases of excess, and practical exclusion of them in the subacid cases. Again it was noted that the results obtained did not warrant the assertion that salt per os or saline proctoclysis was followed by increased acid secretion in the gastric juice.

It would seem, therefore, that the introduction of sodium chloride into the system has no special influence upon the production of hydrochloric acid by the stomach.—*Medical Record.*

THE HYGIENE OF PREGNANCY.—(Edwin B. Cragin, M. D.) The questions most frequently asked a physician by one pregnant for the first time, concern chiefly her dress, her diet, and her exercise.

*Dress During Pregnancy.* The clothing of the pregnant woman should in general be arranged with a view to comfort rather than to suit the taste of the Paris dressmaker. There is no objection to the use of corsets, if they fit properly and can be easily adjusted to the increasing demand for room.

I prefer to have my patients wear a well fitting corset rather than go without. Not only are they more comfortable and suffer less from pain and swelling of the lower limbs, but the child is kept in better relation to the birth canal, especially if the abdominal wall has been stretched by previous pregnancies. This should be borne in mind, however, in the selection of a corset, that what is needed is support from below, not pressure downward from above.

As far as possible the weight of the clothing should be supported from the shoulders rather than the waist, and the stockings should be held in place by side supporters rather than by circular garters, which, with the increased pressure above, favor the development of varicose veins. If the woman suffers from varicose veins, elastic stockings may be needed for support and comfort. Except in very warm weather it is a safeguard for the pregnant woman to protect the skin from sudden changes in temperature by wearing thin flannels.

*Diet During Pregnancy.* In the early months of pregnancy, if the urine is normal, the patient can usually be allowed to select her diet according to her taste, which will often vary greatly from that in the non-pregnant condition. If she suffers with nausea, there are two rules of feeding which will often aid greatly to her comfort:

1. Have her take before rising in the morning, some easily digested food, as a cracker or two, a glass of milk, or some toast and a cup of coffee, and then rest before performing her toilet and dressing.

2. As the feelings of the pregnant patient resemble somewhat the feelings when slightly seasick on shipboard, it is my custom to advise pregnant patients suffering with nausea to follow the custom pursued at sea by eating little and often. The patient usually feels worse when her stomach is empty.

Usually by the fourth month, if not earlier, the patient's appetite returns and she should be allowed a generous plain diet, including meats, cereals, eggs, vegetables, and fruits. During the last month, as will be mentioned later, in order to lessen the work of the liver and the kidneys, the ingestion of red meat may well be limited to three times a week.

The ordinary articles of fluid diet, milk, chocolate, tea, and coffee in moderation are allowable in pregnancy, but alcoholic beverages should be avoided, in order to save the irritation of the liver and kidneys which are already overtaxed.

*Exercise During Pregnancy.* Save in the cases where the woman has suffered from previous early miscarriages, it is advisable to have her take regular moderate exercise.

At the present day one is constantly asked if it is safe for the pregnant woman to motor. According to my experience this depends largely upon



three factors: 1. The mental state of the woman. 2. The condition of the roads. 3. By no means least, the carefulness of the chauffeur.

Every obstetrician of large experience has probably met with cases in which motoring was the apparent cause of a miscarriage. Some women are in such a nervous state whenever they ride in a motor car, that their ride is simply one succession of nervous shocks after another at each sudden turn of the steering wheel.

Still again, motoring with a careful chauffeur who will run slowly, who will avoid the bad places in the road as far as possible, and will take the rough places with the least possible jar, is quite a different thing from a ride with that genus and species of chauffeur which cares for nothing save getting over the road in the shortest possible time.

If the woman enjoys motoring, if the roads are smooth, and the car is run slowly, I believe it does the pregnant woman no harm, and it certainly furnishes diversion and fresh air, both of which are very desirable.

*Care of the Bowels.* Constipation is so common among women in general that in the pregnant state with the increased pressure upon the bowels, resulting from the steadily enlarging uterus, and with the limitation of exercise usually associated with the condition, it is not strange that more or less constipation is the rule, and yet for purposes of elimination it is extremely important that the pregnant woman should have a regular movement of the bowels each day. There are many ways of accomplishing this, but in general, regulation by diet such as coarse food, fruits, and liberal draughts of fresh water between meals are preferable to medicines. When the latter are necessary, the milder laxatives such as some preparation of cascara, or a pill containing aloin, belladonna, and strychnine may be used.

*Care of the Kidneys.* There are two certain indications in the care of the kidneys during pregnancy which may well be impressed upon the laity. In the first place the kidneys during pregnancy have more to do than in the non-pregnant state, as they are called upon to excrete waste products both of the mother and the child. This excretion is favored by keeping the urinary tract well flushed out with large draughts of water, and it is hindered by anything irritating the urinary tract such as alcohol.

It is my custom to advise my patients to drink if possible six glasses of water each day between meals, one before breakfast; two in the middle of the forenoon; two in the middle of the afternoon; and one at bedtime. At the same time I forbid the use of all alcoholic drinks.

*Care of the Skin.* The elimination through the skin of the woman during pregnancy is a process which certainly should not be neglected. For this reason frequent bathing is not only a comfort, but a safety. The temperature of the bath may be determined largely by one's habits, and where a woman has always been accustomed to a cold bath in the morning, I have not found that its continuance during pregnancy did harm. One or two warm baths each week just before retiring, in addition to the regular morning cool bath, will prove of value in increasing perspiration and thus favoring elimination. An extremely cold bath for one not accustomed to it should be avoided. On the other hand, a very hot bath should not be taken.

In the care of the breasts during pregnancy, aside from the support al-

ready mentioned, and the cleanliness maintained by frequent general bathing, the cleanliness and toughening of the nipples obtained by bathing them daily with a saturated solution of borax in fifty per cent. alcohol has seemed in my experience to add greatly to the comfort of the woman during the nursing period which follows.

*The Lungs and Fresh Air.* The elimination of both maternal and fetal waste products, through respiration, and her need of fresh air are often overlooked by the pregnant patient until she finds herself in a crowded room where the air is bad. She then realizes that she needs fresh air and plenty of it, and that she soon feels faint if she does not seek it. Sleeping with open windows and spending a part of each day in the open air are almost essential to a high standard of health during pregnancy.

*Mental Condition.* During pregnancy the mental condition of the woman is usually that of high tension and unstable equilibrium. There are numerous causes for this. She may have found herself pregnant unexpectedly, perhaps unwillingly. Her plans for the year or two to come may have to be entirely rearranged. She may feel like secluding herself from her friends and abstaining from occupations she enjoys. She may feel wretchedly from the nausea which, although made light of by her friends, is disagreeable enough for her. She may dread the ordeal of her labor and last, but by no means least, she may be suffering from a form of poisoning resulting from the lack of elimination of waste products from the body, the results of this poisoning showing themselves chiefly in the nervous system.

The mental condition of some of these women is well illustrated by the experience of one of my old teachers, who said that he had a patient "whose disposition when not pregnant seemed to him angelic, but who acted when pregnant as though possessed of the devil." Certain it is that there is often a tendency to nervous irritability, and the surroundings of these women should be made as cheerful and pleasing as possible, free from all unnecessary causes of fret and worry.

This condition and these needs should be explained to the interested husband, and he should be told that his share, far too small, in the discomforts of child bearing must consist in making allowances for any little irritability on the part of his wife, and in doing all he can to add to her comfort, her diversion, and her cheer.—*New York Medical Journal.*

**KALI IODATUM.**—For a raw, scraped and smarting sensation in the roof of the mouth, fauces and posterior nares, kali iodatum is a valuable remedy. It acts well in the 2x trituration, and I have frequently seen these distressing symptoms relieved in a half hour following a dose of the remedy. Cases presenting symptoms for its use are not necessarily syphilitic in character.—*A. E. Hinsdale.*

**METASTATIC GONORRHOEAL IRITIS TREATED WITH NEISSER BACTERIN.**—Dr. Edward A. Shumway showed a patient from the wards of the Philadelphia General Hospital, who had recovered from a severe attack of bilateral gonorrhoeal iritis after treating with Neisser bacterin. The patient, a male, aged twenty-five years, had had four recurrences in five years, and had an associated arthritis of the hip joints. An injection of a dose of

50,000,000 organism was followed by decided improvement, and a second one of 100,000,000, which was administered one week later, produced still more prompt response. All photophobia and pain disappeared, and after two subsequent injections of 200,000,000 and 300,000,000 respectively the ciliary flush cleared up entirely and the eyes remained quiet. No other general treatment had been given. Dr. Shumway said that since he had reported a similar case February, 1910, the paper, which had been written had tended to confirm the results collected at that time, viz, that the injections were of but little avail in gonorrhea of the urethral tract and the immediate adnexa, and in gonorrheal conjunctivitis, but that they had proved very serviceable in metastatic involvement of the joints and iris. Recently, however, Palmer, of New York, had reported some success in acute gonorrhea and in gonorrheal ophthalmia. Uhle and Mackinney, of Philadelphia, believed that the serum was more effective than the bacterin. A minor disadvantage of the use of the serum was the occasional occurrence of urticaria after the injection.—*Annals of Ophthalmol.*

WILLIAM SPENCER, M. D.

AN UNUSUAL CASE OF STEEL INJURY.—Two years ago the patient, aged 17, was hit in the right eye by a piece of steel which perforated the cornea and lens, but did not remain in the eye. A cataract was produced which gradually absorbed, leaving him with vision of 20-20 with correction. November 27, 1911, while striking two hammers together he was again struck, this time in the left eye, by a piece of flying steel, which perforated the upper eyelid, cornea, iris and lens. X-ray could not be taken. Giant magnet was used but with no response. Sclera was then opened between the external and inferior recti muscles and magnet used freely. No result and no reaction from the operation. Five days later a radiograph was taken which showed the steel centrally located either in the sclera or back of it. The radiograph was taken, part of the exposure being with the eye directed forward, finishing the exposure with the eye turned to one side. In this radiograph two pictures of the foreign body were visible, showing that the steel moved with the eye. Evidence of trouble appeared and a search for the foreign body was made by first opening behind the eyeball. Meeting with no success the eyeball was opened at posterior position and this proved a failure to locate the steel. The globe was enucleated and the steel was found in a mass of exudate which was attached to the eye ball.—Dr. Frank Allport, *Ophthalmic Record*.

WILLIAM SPENCER, M. D.

ARGENTUM NITRICUM.—The therapeutic result obtained by this remedy in ulcer of the stomach is almost constant according to Dr. P. Jousset. The diminution of pain is the first sign of its favorable action. The 6th centesimal dilution is advised.

KREOSOTE.—One of the first remedies for reflex or sympathetic vomiting. It is also sometimes useful in vomiting, symptomatic of an organic stomach affection.



## Monthly Retrospect

### OF HOMOEOPATHIC MATERIA MEDICA AND THERAPEUTICS

CONDUCTED BY A. LEIGHT MONROE,  
Miami, Florida.

**MATERIA MEDICA KEYNOTES.**—Frederick Kopp, Greenwich, N. S. W.  
*Magnesium Phosphoricum in Pains.*—*Magnesium phosphoricum* is valuable in pains in affections of the nerves, where the slightest pressure is more painful than a strong pressure, when given in the 6x trituration. The 6x trituration is also indicated in spasmodic pains of the stomach and bowels, which are *cutting, griping, and drawing*, causing the patient to double up, and is increased on the slightest movement, the tongue being clean. In pains, resembling the colic, where the abdomen feels cold to the touch, and is swollen, it is best alternated with *Kali sulphuricum* 3x. It is most effectual when administered in 5 grain doses in *hot water*. In pains in the left side, with flatulent pressing on the heart, it should be alternated with *Kali phosphoricum* 2x.

*Guaicum in Ankle Pains.*—This drug is indicated in pain in the ankle, extending half way up the leg, causing lameness. It is best administered in the third centesimal potency, every four hours. When there is great sensitiveness to the touch, it should be alternated with *Lachesis* 6.

*Chionanthus Virginica as a Liver Remedy.*—This remedy is indicated by clay-colored stools, high-colored or brown urine, yellowness of the conjunctiva and the skin, uneasiness or pain in the region of the liver or right hypochondrium, abdominal pains or colic, and great prostration. It is one of the best remedies in jaundice, when due to functional disorders of the great hepatic gland. It has the property of assisting in the prevention of gall-stones, and in their expulsion. It is indicated in slow convalescence following exhaustive diseases. It is useful in hypertrophy of the liver, consequent on obstruction of its ducts, or of a malarial character, and also in bilious colic. The dose is five minims of the tincture in a wineglassful of water five or six times daily.

*Cactus grandiflorus in Acute Carditis.*—In acute carditis, *Cactus grandiflorus* is indicated when the following symptoms are present: Oppression of breathing, *bluish* hue of the face, pains of a pricking nature in the heart, dry cough, inability to lie on the left side; the pulse quick, hard, tense, and throbbing. In the chronic condition it is indicated when the face is *cyanotic* and oedematous, the respiration is of a suffocating character, a dull pain is continuous in the heart, and *the whole body is dropsical*, hands and feet cold, pulse *intermittent*, and inability to either speak or drink.

*Natrum phosphoricum in Jaundice.*—*Natrum phosphoricum* 1x in 5 grain doses, four times daily, is indicated where the patient gets sick suddenly, complaining of biliousness, with sometimes vomiting, and spasmodic looseness of the bowels. The attack makes rapid progress, the evacuations are green and bilious, the tongue is coated a greenish-brown, the skin yellow, and the whites of the eyes a dirty-yellow. If the kidneys are also affected, the remedy should be alternated with *Ferrum phosphoricum* 3x.

*Carduus Marianus in Influenza.*—This remedy is indicated in those cases of influenza in which the liver is affected. The left lobes of the gland are very sensitive to pressure, the stools are of a bright yellow color, the urine is a dark brown; there are occasional stitches in the side, and great oppression in the chest. There are also great debility and fever present, besides much prostration. A headache of a frontal nature worries the patient, and the complexion is of a most peculiar brownish-grey dirty hue, and at times of a jaundiced color. From 2 to 3 minims of the 1x dilution, administered every three or four hours usually promptly cures, even after other prominent hepatic remedies have failed. *Carduus Mar.* has for its analogues, *Podophyllum peltatum*, *Chionanthus Virginica*, *Leptandra Virginica*, *Bryonia alba*, *Nux Vomica* and *Chilidonium majus*—all proved hepatic remedies. It is an important remedy in cases where there is pain in the liver, accompanied with œdema of the feet, urine of a bright yellow color and scanty, and occasional attacks of asthma. In fact, "asthmatic" respiration is a prominent symptom of the drug. In swelling of the gall-bladder, accompanied with a painful tenderness, it is one of our first remedies.

*Epigea Repens in Gravel.*—This remedy should be thought of, the discharge resembles *fine sand*, of a *brown* color. There is usually a sensation of burning in the neck of the bladder whilst urinating, and tenesmus of the organ afterwards. It is best administered in the tincture, 3 to 5 minims thrice daily.

*Trillium pendulosum in Phthisis Pulmonalis.* This remedy is an analogue of *Hamamelis Virginica*, and is of great benefit in the treatment of consumption of the lungs, when the cough is troublesome, accompanied with purulent and copious expectoration, and spitting of blood. It has a wonderful power over hæmorrhage, and of great value as a mouth wash after dental extractions. It is also indicated in those cases of dysentery, where the evacuations are almost of pure blood. Two minim doses of the tincture every two or three hours—every hour, till improvement sets in, in cases of dysentery.

*Balsamum Peruvianum in Hectic Fevers.*—This remedy is unsurpassed in the treatment of hectic fevers either in phthisis pulmonalis or chronic bronchitis. It acts best when given in the 6x dilution. Debility is a characteristic symptom of the drug, and there is often present a catarrhal state of the stomach. I have found it very useful in cases where the expectoration is purulent and profuse. In these cases the 1x dilution is the most efficient.

*Atrophine—a throat symptom.*—In its proving this drug has the characteristic symptom of great *dryness of the pharynx*, so that the prover finds it almost impossible to swallow; in fact, he is unable to swallow anything solid without washing it down with some liquid. The act of swallowing

is also liable to give pain, and to produce paroxysms of suffocation. In cases of sickness where the above symptoms, or any of them, are present, *Atropine* has proved a very valuable remedy, when given in from three to five grains of the third centesimal trituration, three or four times daily.—*Homœopathic World*.

**RHEUMATISM IN CHILDHOOD.**—The homœopathic treatment of rheumatism in general would be far too large a subject to undertake here. I wish merely to refer to a few drugs that I have found useful in those early stages of puerile rheumatism with which I have been chiefly concerned in this paper.

Many of these children, I think, require calcarea hardly less than do the scrofulous, at some time or another. Although they are not fat or what is called leucophlegmatic, a certain class of them are phlegmatic, pale, with dark rings under the eyes, very chilly, very liable to take cold, liable to localized sweats (especially about the feet, which at the same time are icy cold), and usually constipated; the eyes, too, show the bluish-white sclerotic referred to before. Calc. phos. may sometimes be preferred to calc. carb., as the calc. phos. patient is said to be thin.

An obvious alternative to calcarea thus used would be silica, which has the same chilliness and lack of vital heat, a great susceptibility to taking cold, and a rheumatic type of headache beginning in the nape of the neck or occiput and coming forward over the whole head. Silica is further indicated when the rheumatism settles in the soles of the feet. Moreover, silica has the symptoms, in italics, of "somnambulism," a feature in some of these cases.

Another deeply acting remedy, which may be thought of when other things fail, is medorrhinum. It has the great chilliness—not only cold feet and hands, but chills up and down the back; it has pains in the soles and heels, which are very sore, and the feeling of legs too heavy to lift, which is a very common symptom of rheumatic children. It also has marked nocturnal enuresis, a nervous symptom which is often a precursor of chorea. Such rheumatism need not be of gonococcal origin in order to be appropriately treated with medorrhinum.

The rheumatic pains, attacking by election the fibrous, fascial and tendinous tissues, will often call for such remedies as rhus tox., ruta, rhododendron, and phytolacca. These are remedies so well known to you all that it is not my purpose to speak in detail upon any one of them. None of them is so well proved as rhus. Ruta, indeed, appears to resemble rhus rather closely, and in particular has the rhus modality, "worse at rest or lying down." It has, moreover, an italicised symptom, "thighs pain when stretching the limbs." This symptom would certainly come in when the hamstring tendons are affected, as they often are in puerile rheumatism. Rhododendrum has a well-marked modality—"worse before a storm," and this might prove to be a "leader." Rhus tox. and phytolacca are very similar, and I have often wavered between them in seeking a remedy for rheumatism. They have very similar kinds of pain, they affect especially fibro-muscular structures, and they are worse in cold, damp weather. One of the typical modalities of rhus is the improvement or



"limbering up" from movement, walking and change of position. This differentiates it most strikingly from bryonia, but phytolacca also, like bryonia, is aggravated by movement. Now the young rheumatic is generally better, as regards his pains, when he is at rest. If he has tonsillitis also, as he is liable to have, the indication is on the whole for phytolacca. If the rheumatic pain, especially affects the heels, as I have seen it do, this will certainly incline us to phytolacca, which appears to have a special affinity for the heel. Phytolacca may be further indicated by those rare cases in which female children of rheumatic history have mastitis; for phytolacca certainly has an affinity for the tissues of the breast. A vesicular irritating eruption sometimes seen in puerile rheumatism might, together with the characteristic rheumatic pains—worse by cold and worse in damp weather—point by preference to rhus.

Another remedy that we shall be almost sure to use at some time is dulcamara, a drug whose symptoms correspond to conditions brought on by damp weather or exposure to wet. It also has icy coldness.

I do not propose to say much of chorea. I need only name ignatia, zincum, cuprum, mygale, and tarentula. I have found agaricus of more use than any other remedy, largely, I believe, because in addition to the choreic movements and rheumatic pain and stiffness, it has a chilliness and tendency to chilblains not found in the other choreic remedies. The next most valuable remedy in conditions of chorea with marked fibro-muscular rheumatic pains is in my opinion actæa racemosa.—Dr. T. Miller Neatby, Feb. No. *British Journal of Homoeopathy*.

MORPHINE.—The use of morphine and scopolamine before a general anæsthetic brings with it dangers which are not compensated by any advantages, and the method should be abandoned or limited to specially selected cases.—*Medical Review of Reviews*.

BAPTISIA.—6, 12 or 30 in spasm of the œsophagus. It suits men as well as women of a nervous constitution who, at the commencement of a meal, experience a hindrance in swallowing the first part, but swallow better towards the middle or end of the meal. I have many times verified this use of the remedy. I prefer it to ignatia. Baptisia is well indicated in vomiting, more or less abundant, occasioned by œsophageal spasm. Regurgitations due to œsophageal anti-peristalsis.—*Cartier*.

KALI BICHROMICUM. Aphonia due to cold or a mild attack of laryngitis will generally yield promptly to a weak solution of potassium bichromate, both internally and locally as a spray. Ipecac, used in the same way, often yields the most prompt and signal relief. If there is fever the indicated antipyretic is most often specific aconite. When the attack has lasted several days, potassium bichromate, stillingia liniment, collinsonia and capsicum may be considered. We have seen many cases of hoarseness and aphonia yield quickly to freshly prepared horseradish (*armoracia*), with vinegar, eaten sparingly with food.—*The Eclectic Medical Gleaner*.

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## PERSONAL EXPERIENCES WITH SALVARSAN IN THE TREATMENT OF SYPHILIS.

BY

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(Read before the New Jersey Homœopathic Medical Society.)

OF the three miasms recognized by Hahnemann, viz.: Syphilis, sycosis and psora, perhaps the first has occupied the greatest place in the minds of both the laity and the profession. In fact, I think the cure of syphilis may be conceded the *bete noir* of the practice of medicine.

This has led to much writing and experimentation in the various methods of attacking this dreaded malady, in the hope of permanent cure.

Until recently mercury, in some form or other, has been the routine treatment of syphilis. Now, however, there are a number of organic compounds of arsenic, which have been proven to have parasitotropic properties, chief among which is that chemically known as dioxy-diamino-arseno-benzol-di-hydrochloride, and commonly known as salvarsan, or 606.

For the therapeutic value of this compound, in the treatment of syphilis, we are indebted to Professor Ehrlich and his collaborators, among whom Hata, of Tokio, is specially mentioned.

It is not the purpose of this paper to go into the chemistry of salvarsan—simply to speak of its merits as a therapeutic agent.

When salvarsan was introduced to the profession, it was re-

ceived with a great deal of enthusiasm, and generally looked upon as a panacea in all forms and conditions of syphilis. This, however, was not claimed by Ehrlich, as he specifically states that it is only efficacious in well selected cases, with due regard to the physical condition of the patient; such as the condition of the heart, the kidneys, the eyes, and the nervous system. Doctors Martindale and Westcott, of London, give as contra-indications for the injection of salvarsan, the following:

- (a) Severe non-syphilitic retinal and optic disease;
- (b) Severe heart and vascular disease;
- (c) Severe lung affections;
- (d) Severe non-syphilitic kidney affections;
- (e) Advanced degenerative processes of the nervous system;
- (f) Those suffering from angina and fever.

This author also views infantile congenital syphilis as a contra-indication.

Ehrlich declares patients with very advanced degenerative changes of the central nervous system, should not be treated either intravenously or intramuscularly with salvarsan. Following the injection, there is sometimes noticed a fall in blood pressure, which in cases of cardiac debility, may occasionally become dangerous.

Having defined the contra-indications for the successful administration of salvarsan, and given a positive case of active syphilis, which we have proven to be positive by means of the Wassermann or Nagouchi serum tests, we are next to decide the dose and form of injection.

The dose ranges from five-tenths gram to one gram, according to the nature of the case; that is, its physical condition, its toleration, and the extent of infection, but the usual dose for an adult male is six-tenths gram.

Salvarsan may be injected either subcutaneously, intramuscularly or intravenously.

The technique for injecting is elaborate and requires the same degree of care as to sterilization of both the site for injection and all instruments used in its preparation, as is observed in surgical operations. Furthermore, patients treated with this powerful acting remedy, should be kept under the constant watch of the physician for possible unfavorable symptoms, as well as to observe the degree of elimination of the arsenic, as evidenced by the kidneys and skin.

Authors differ slightly as to the best means of administering



salvarsan, some favoring the intramuscular, and others adhering to the intravenous method. Personally, the writer has employed only the intramuscular injection, selecting the intragluteal muscles.

There is little to be said in favor of the intramuscular form over the intravenous, other than that it is slower of absorption, and correspondingly longer in action, and is more easily accomplished, and the apparatus is less complicated.

The intravenous method offers the great advantage of accuracy of dose absorption, is less likely to infect and form necrotic areas, and is less painful. Some authors advise following the intravenous injection by an intramuscular one, in order to prolong its action. When this is done, a few days to one week should elapse between the injections.

A popular and successful method of giving the intramuscular injection of salvarsan, is that of Alt, he being an associate of Ehrlich. This is very accurately described by Martindale and Westcott, and is as follows:

In a 100 c.c. stoppered graduated cylinder, add 10 c.c. of distilled water, and then the powder. By slight shaking, the substance is easily dissolved. For every one-tenth gram of the substance, add five-tenths c.c. normal Na. Oh., and shake again energetically for about half a minute. This forms a perfectly clear and slightly alkaline solution, which can be diluted as desired 20 to 30 c.c. This is slowly injected, preferably into the gluteal muscles. The preparation does not always require the same quantity of Na. Oh. By this method, the smallest quantity of Na. Oh. is used, and hence produces the least pain.

There is also a method used by Michaelis, and modified by Spiethoff, known as the neutral suspension, and has been used by the writer, but has no particular advantage over that of Alt. It is said to be less painful, being practically free from irritant of acid or alkali, but it has been my experience that the great percentage of pain is due to the manner of injecting, rather than to the degree of alkalinity.

A point observed by the writer, was to massage the muscle slowly injected, and to add to the comfort of the patient, to rub in some cocoa butter. As previously stated, the cases herein mentioned were injected by the intramuscular method; therefore, the writer will not go into the technique of the intravenous method. The writer has injected some ten or twelve private cases, and offers two for consideration, having opposite phases:

CASE I.—Mr. S. occupation, machinist; personal and family history negative. Became infected October, 1910, prepuccial chancere. Received mercurial treatment until January, 1911, by a Chicago physician. Presented himself to me for treatment, and was injected with six-tenths gram solution of salvarsan, intragluteally, in January, 1911. He showed the prepuccial scar, erythematous eruption on face, arms and chest; had some headache and sore throat, with mucous patches. In addition to the symptoms, the patient also presented an unusual condition, in the form of an extra genital lesion, having inoculated his thumb after an injury received by an emery wheel grind. This produced a perfect picture of chancere, and resisted all local treatment to heal. He showed signs of healing twenty-four hours after the injection of salvarsan, and was entirely well five days later.

Having a perfect history of specific infection, and with the double evidence of local infection, there was no preliminary blood examination made, and the patient was not treated medically, but kept under surveillance for three months, at the end of which time his blood was taken for the Wassermann reaction, which was in March, 1911, and proved negative.

A second blood test was made three months later, June, 1911, and gave a faintly positive result. The patient gave no evidence of existing infection, other than slight rash and an occasional sore throat, but it was decided to give a repeated intramuscular injection, and of the original dose, viz.: six-tenths gram. This was attended by the usual reactionary symptoms of thirst and mild fever, with restlessness.

In September, three months later, a third test was taken and proved negative to both the Wassermann and Nagouchi reaction.

Another test was made in January, 1912, just one year from the time of the first injection, and was found to continue negative.

This being my first case of the salvarsan injection treatment of syphilis, and since it was such a decidedly positive case originally, and also since there have been some claims that one could only affect a negative phase for a short time, has caused me to follow the case rather closely. I, therefore, asked my patient to allow of another blood test, April 15, 1912, this being his fifth, and am delighted to report it still continues negative, and there are at the present time no clinical signs of syphilis.

To summarize this case: With his initial injection in January, 1911, with one slightly positive reaction the following June, and no recurrence of the positive phase since, and in absence of any clinical evidence of an existing infection, I feel I can pronounce him cured, and entirely so by intramuscular injection of salvarsan.

Permit me to offer one more case for your consideration:

Mr. H., age 30; occupation, hotel clerk; referred to me by a prominent local dentist; presenting dental caries and mucous membrane lesions of the buccal cavity, of evident syphilitic nature.

The patient had a history of syphilitic infection some five years previous, and had some of the ear marks of the secondary stage, so much so that I injected him last August, taking his blood just a few minutes before, and which was analyzed the following day after injection, giving a negative reaction to the double test of Wassermann and Nagouchi.

Having, as stated, all the ear marks of an active infection, led me to inject first and test after, a very unwise thing to do; for so great was the absorption of the arsenic administered, that the patient suffered a most profound reaction, having high temperature, intense thirst, with irritable stomach, not being able to tolerate any food for a short time; diarrhœa and intense headache. Because of the sufferings of my patient, together with my then somewhat limited experience in the use of salvarsan, and I think I might add, my fear of possible public anti-sentiment, I called Dr. L. T. Ashcraft, of Philadelphia, in association on the case, and he can verify my statements.

However, these unfavorable symptoms passed off in about one week, and my patient was able to return to his former employment in another week, seemingly none the worse for his experience. In fact, I might add, his previous symptoms seemed to quickly disappear, even to the cessation of his falling hair, which symptom I had forgotten to mention before. Some authorities mention the tendency of necrosis following the intramuscular injection of salvarsan, but I am glad to report an absence of this in my experience.

My testimony for salvarsan then, is that it is of therapeutic value in the treatment of the active stage of syphilis, its activity being determined by the serum test, either Wassermann or Nagouchi, and preferably the latter, it being a more deli-



cate test, according to Dr. F. S. Hammond, pathologist of the State Hospital for the Insane at Trenton, N. J., who has made the blood tests of the cases just cited.

Dr. Hammond says:

"In sensitiveness the Nagouchi modification offers advantages over the original Wassermann, because of two factors:

"(1) from 85 per cent. to 90 per cent. of all human sera, either normal or pathological, contain natural antisheep amboceptors in such quantity as to be in themselves sufficient to produce hemolysis of the sheep cells used in the original Wassermann method without the addition of the artificial rabbit anti-sheep amboceptor.

"For this reason there is very commonly an excess of amboceptor present in a given reaction; and should any of the complement be left unmixed (as is the case with weakly positive syphilitic sera) this amboceptor excess may bring about complete hemolysis, thus transforming a positive into a negative reaction.

"(2) The antigen recommended by Nagouchi (pure tissue lipoids) allows the selection of such a unit that 20 times this amount will not be prejudicial to the accuracy of the reaction by either an inhibitory or hemolytic activity; whereas the Wassermann antigens are commonly so inhibitory, hemolytic, or both, that it is not possible to use a quantity of antigen which will be sufficient to always detect the presence of syphilitic antibodies in a weakly positive serum.

"It can be readily seen from these considerations that the Wassermann, when positive, is perhaps the safest evidence of syphilis. And in reverse order that a negative Nagouchi offers a better indication of the absence of syphilis than does a negative Wassermann."

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THE PASSING OF BISMUTH PASTE.—Wallace Blanchard, Chicago, *Medical Record*, May 18, 1912. Having successfully treated 108 tuberculosis sinuses with Beck's paste, and 152 cases with a non-toxic substitute even more successfully, the author certainly speaks from experience. The main disadvantage of Beck's formula is that occasionally the bismuth is toxic, and deaths have been reported in an appreciable number of instances. Beck's theory that the bismuth serves as a sort of radium-emanating substance, and is therefore essential, the author regards as fanciful. Blanchard has therefore devised a substitute which is non-toxic and equally efficient. This formula is: white wax, 1 part; vaseline, 8 parts; mix while boiling. In badly infected cases sodium is added. For purposes of radiography the author offers a formula of 33 1-3 per cent. iron subcarbonate in white vaseline. This throws a shadow equally as well as bismuth, and is non-toxic.

**THE SOCIAL EVIL---THE DUTY OF THE PHYSICIAN.**

BY

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(Read before the Surgical and Gynecological Association, A. I. H., June, 1912.)

No intelligent discussion of the many phases of the social evil is possible without first tracing, in an evolutionary way, the development of the sex instinct and its influence upon character.

Physiologically its possession is absolutely necessary for the perpetuation of species. Without it all the lower forms of life would cease and even in man it is difficult to imagine that children would be brought into the world were the promptings on the part of ancestry purely altruistic. Without it, too, men and women would be supine and characterless, the world's divine sonnets would never have been written, the great conquests of explorers would never have been recorded, the sublime melodies of Beethoven and Wagner and Mendelssohn would never have been created and most of the great victories in battle would never have been won. I do not mean to infer that inspiring poetry must necessarily be written by men and women whose thoughts for the time being are not above matters sexual; that explorers like Columbus and Perry and Drake were in any way directly inspired to undertake the tasks which have made their names household words by the sex impulse; nor that Beethoven and Wagner and Mendelssohn were laboring under immediate sexual excitement when they composed for you and for me, and for the generations that are to follow, those transcendent melodies which lift us almost to heaven. The thought I am trying to emphasize is that the normal sex impulse makes men brave and ambitious, willing and anxious to dare and to do, patriotic and chivalrous, with a love for home and a desire to perpetuate their kind. In women it makes for contentment and nobility of character, and inspires a longing for motherhood, its final consummation, and a love for husband and home. In nearly all instances where extraordinary vigor in old age manifests itself, as in the case of Goethe, whose life is reflected in his character of Faust, sexual vigor is preserved.

The normal sex impulse must then necessarily be reck-

oned with in studying the human body and its various functions. The function of reproduction is as much one of its functions as are digestion, assimilation, elimination, and those of the special senses. Indeed, it is the most imperious of all the functions, and luckily so, for were it not the human race, as I have already shown, would become extinct. In the lower animals it is never called into action, except for the purpose of creating new life. The male never approaches the female, except at such times as nature has created a desire on the part of the female by the ripening and discharge of an ovule which requires for its fertility contact with the male element. At such time the male does not attract the female but the female attracts the male. In many instances, too, the male is mated with two or more females; never will there be found more than one male mated with a single female. These well known biological facts—the attraction in lower animals of the male by the female, and the bigamous character of the male—should be borne in mind in our study of the question under discussion and will be referred to later.

It is also a well known fact in evolution that the farther we get away from the primitive forms of life the more complex do organizations become. Man, the highest developed of living organisms, possesses a correspondence infinitely greater than does any other living thing. Because of his greater intelligence he conquers his environment and protects himself from heat and cold and the dangers of famine and hunger. To a lesser degree this is also true of many of the lower animals, but man's superior intelligence enables him to devise ways and means which are never to be found in animals governed only by instinct. He builds houses, no two exactly alike, that he may keep cool in summer and warm in winter. He protects his body, once covered with hair, with clothing. He paints pictures which please the eye; he creates melodies which make him happy or sad as the case may be; he devises dishes which excite his palate; and he conquers the very elements that they may minister to his pleasures and his necessities. But in accomplishing all this he has deviated from type, and in no particular more so than in his sexual habits and sexual life.

From the very dawn of civilization, and probably for infinite ages before the earliest record of that dawn, man has gratified his sexual promptings for purposes other than the perpetuation of species. So long has this continued that the



perpetuation of species has finally become an incident of the sexual act rather than its primary object, and the sexual habit in humans has developed into almost as much of a habit as are eating and sleeping. In women the desire is intensified by ovulation, the function of menstruation, which occurs every twenty-eight days; and in men by the retention of a somatic substance which irritates the nerve endings in the seminal vesicles. In both instances there is created a psychic impulse which creates a craving for relief from the libinous tension. Such relief is to be had normally only through sexual contact.

There are many eminent men in the medical profession, Freud of Vienna being perhaps the best known, who believe and teach that in the sexually ripe male and female, an adequate sexual discharge is necessary for the maintenance of health and that if the discharge is inadequate, there frequently results a serious apprehension neurosis. I cannot entirely agree with this conclusion but Freud and his school of psychologists have at least opened up a new field of thought which is being carefully worked by many conservative specialists, who through dream analysis and association tests, are solving problems which have long remained unsolved. Sufficient for present purposes is the fact that for thousands of years man has indulged in sexual relations for the purpose of relieving nerve tension incident to an accumulation within his body which excites a powerful psychic stimulus, quite as much as for the purpose of procreation; that for thousands of years he has lived a polygamous and communistic life, marriage becoming a necessity only after property interests became a factor in his social relations; and that his present monogamous life, compared with the far gone past, is yet an experiment which requires for its complete success certain moral attributes on his part, which are all too often lacking, and a reversion to type is not an infrequent consequence.

These well known biological facts enable us better to understand the causes which are responsible for the social evil and which we have to contend against in working for its extinction. For present purposes it matters but little when and how venereal diseases first infected the human race. It is quite enough for us to know that both gonorrhea and syphilis are here; that both are responsible for untold agony and unhappiness; and that both are in large measure perpetuated by prostitution. If the prostitute could therefore be eliminated from

our social system, it would go a long way toward the final suppression of the so-called specific diseases.

Unfortunately the prostitute herself is but the end product of that system and is more to be pitied than condemned. Her ranks are recruited from the underpaid work and shop girls, from the offspring of ill-assorted marriages in the consummation of which the very fundamental principles of biology are ignored, from the victims of an inherited instinct which in an unguarded moment overwhelmed its possessor, and from woman's own attitude toward the unfortunate girl after her shame has been revealed to the world. While she still suffered from remorse of conscience, and there remained in her heart the love of home and life and children, she might have been reached had society done its full duty and not condemned her to wear during her remaining years the scarlet letter. She was ostracized, she was unable to obtain employment, and after she began to experience the pangs of hunger and want, she took the course of least resistance and commercialized her body and soul. As time went on, and her years were not many, in spite of rouge and paint and artificial adornment, her beauty and freshness vanished. She almost without exception became a victim of alcohol and narcotics and disease, and developed into the lowest of God's creatures. Driven to bay by the State, like her crawling prototype of the jungle, she turned upon the very society which pushed her into the vortex which sucked her down to death and destruction, and struck, not with her fangs but in a much more deadly way, by leaving along her devious track through life the spew and spawn of disease. And this vicious circle has continued until everywhere men and women who have at heart their brother's keeping are asking the question, "How can society best protect itself against this great social evil of prostitution and sexual perversion?"

Like thousands of other questions this one is more easily asked than answered. My own solution is foreshadowed by what I have already said. It is an underlying principle in medicine that before any disease can be cured the *cause* must be removed. Then, too, we are living in an age of prophylactic medicine and it is always infinitely easier to prevent than to cure disease. Again, the more deeply seated a disease becomes the harder it is to eradicate, and the social evil has been with us for thousands of years. No system of cure, therefore, can be immediately successful. Nor can any system

of cure which ignores the great biological facts, which I have but barely outlined, expect to accomplish little more than mere palliation. Indeed, I am not sure that if every prostitute in the land were eliminated to-day, it would be quite safe for your daughters and mine to walk alone the streets of our cities and our villages, so long have the unbridled passions of certain men run riot; and if they were exterminated, with the causes enumerated left operative, a new supply would be speedily forthcoming. As well try to stop the eruption of a seething volcano by closing its crater as to stop prostitution under existing conditions. If my language is pessimistic, it is that of a pessimism begot by years of study of this great question at close range. But a healthy pessimism is infinitely more desirable than is a contented optimism which is entirely satisfied in the belief that all things, without individual or collective effort, will in the end come right.

My own theory of correction therefore naturally comprehends those methods which bring us into closer harmony with nature's laws, which is but another way of saying God's laws. But Nature's laws, though immutable, usually require time, often infinite time, before perfection is possible. The best that we of to-day can do in order to accomplish permanent results is to begin with the unborn child of to-morrow. Through evolution God has given man the chance to work out his own salvation and the salvation of his race. We of the present generation are paying the penalty of the sins of our forefathers, who may have been the victims of the third and fourth generation of their forefathers. But we of the present generation are in possession of knowledge which our forefathers knew not of, and if we do not use our ten talents to the betterment of posterity we are shirking our responsibilities. And this brings us at once to a consideration of the new science of eugenics, the progress of humanity through improved conditions in the relation of the sexes, which has but recently received such a great impetus by the action of the very Reverend Walter T. Sumner, of Chicago, in declining to solemnize marriages in which both parties cannot show by medical certificate that they are in good mental and physical condition.

The time is all too short to permit but little more than reference to this great object. For countless generations men and women have ignored the results obtained by the breeders of cattle and horses and sheep and dogs and cats and chickens,



and all living things lower than man, by the process of careful selection—Nature's law, God's law. Mendel has even demonstrated the possibility by this process of reproducing colors in the feathers and hair and eyes with a scientific precision that makes of selection almost an exact science. Has the time not come when it is possible for intelligent men and women to profit by the experience of the stock breeder in bringing into the world human beings? What a race of Spartans we could produce were that law applied, say for ten generations! The State makes it a misdemeanor to breed diseased horses and cattle and hogs, but it interferes in no way, except in rare instances, in the mating of men and women who are from tuberculous, cancerous, syphilitic, or neurotic ancestry. This thought is not new, for more than fifty years ago Sir Francis Galton, in his work on "Heredity in Genius," showed how undesirables come into being and how they may be prohibited, and we of to-day are stamping his ideas with our approval. I am still old fashioned enough to believe that men and women should marry for love; but there is a vast difference between the love which is prompted by judgment and good sense and that which is based upon a silly sentimentality which ignores every known law of heredity. No legal or theologic formula can make in the sight of God a man and woman one who by temperament and in physical attributes are as unlike as are virtue and lust. If, therefore, the State is going to proscribe the marriage of the victims of venereal disease, let it go farther and proscribe the marriage of the victims of all hereditary diseases, either physical or mental.

But the day when the State will presume to do this is a long way off, and in the meantime all that we of the medical profession can do to hasten its consummation is to continue our campaign of education and care, to the best of our ability, for the victims of the existing system. Our boys and girls, instead of being permitted to grow up in ignorance of all matters sexual, should receive instruction in the public schools and in the homes in the function and care of the reproductive organs. Both should know the penalty of digression from well known physiological laws. If the boy in the supreme conceit of his young manhood doubts the existence of a Creator, take him into the hospital ward where he will see that "as a man soweth that shall he also reap" is Nature's if not God's law. Do not let him go out into the world ignorant of the world. Teach

him that wherever he goes he will find on every hand all sorts of temptations and that if he is to resist them he must possess moral stability, which he cannot have if his inhibitory centres are paralyzed by alcohol and narcotics. Let the girl be taught that her role in the reproductive act is infinitely more important than is that of the opposite sex. Point out to her the great biological fact which I have already called attention to, that throughout the eons of time required for man's descent from the lower forms of life the female was unmolested by the male, unless by some token the aroused sexual instinct in the female was made manifest. I mean by this that, with the possible exception of the degenerate who will commit both murder and rape in order to appease his inordinate sexual excitement, the true gentlewoman will never be improperly approached by a man of even ordinary gentility, if she conceals from him her own physical longings.

The prostitute, in my opinion, should be segregated, and when infected quarantined. This, of course, implies governmental control and inspection. I am fully conscious of the fact that where this experiment has been tried it has not proved entirely successful, but the factors going to make it so were in nearly every instance wanting. Bacteriology has only recently become an exact science and it never before was possible to detect with almost absolute certainty the presence of gonorrhea and syphilis. This is now possible, so that if the inspection is placed in competent hands, independent of political influence and graft, it ought to go a long way toward lessening the number of venereal diseases. The theorist will doubtless insist that if this is done in the instance of prostitute, all men and women the victims of venereal diseases should also be reported and quarantined. My answer is that the man who has to his horror and humiliation contracted the disease is not hypothecating his body, as does the prostitute, that he may live; that exposure in his case would mean ostracism and ruin, as it would also in the case of the unfortunate girl who has likewise contracted the disease; and that in both instances it is entirely possible to restore the victims to health and make of them useful members of society.

I have in another place \* gone into a detailed discussion of the dangers attending the marriage of the victims of gonor-

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\*"The Tragedy of the Gonococcus."

rhea without thorough and repeated examinations by a genito-urinary specialist. What is true of gonorrhea is also true of syphilis. Both diseases can be so cured as to make marriage relatively safe. It is up to the State to be sure that both diseases are cured before permitting its consummation. I myself took the initiative in having eliminated from our national code of ethics, in order to protect the bride to be, obligation to keep secret knowledge obtained during professional duty when such secrecy may result in probable harm to others.

I only want, in conclusion, to call the attention of the medical profession to the probability of creating wrong impressions regarding man's constancy in our efforts to arouse a lethargic public to the dangers of venereal diseases. We must not forget that the physician's office is the catch basin into which is washed much of the sewage of humanity. We need an occasional view of the clear sky in order to keep us from becoming morbid and sick at heart. We are too apt to conclude that the exceptions prove the rule. The average American husband is a hard-working, home-loving man devoted to his wife and family, as a rule working all too hard that he may supply their wants and protect them from the sting of poverty when he is gone. Home to him is a sacred thing and he stands ready to defend it, if need be, with his life. It only requires some great crisis like the one whose shadow is still hovering over us—the sinking of the Titanic—to demonstrate his chivalry and his manhood. I am quite ready to believe, too, that the percentage of gonorrheas in unmarried men is over-estimated. The actual conditions are bad enough in all conscience, so do not let us represent them worse than they are. I believe, too, and most sincerely, in the chastity of the great majority of American wives and mothers. As a nation we are neither effete nor degenerate. On the contrary, we are in the very vigor of young statehood and one of the best indications of our stability and our strength is the manner in which we of the present generation have risen in our might in our endeavor to solve the great problem of the social evil.



**THE DIAGNOSIS OF GASTRIC ULCER.**

BY

RODMAN SHEEN, M. D., PHILADELPHIA.

A CASE of gastric ulcer as generally expounded in the books on diagnosis to-day, would typically present the picture of an anemic, somewhat emaciated individual of middle age, having a symptom complex somewhat similar to the following: pain and tenderness which is located in the epigastric region just below the ensiform cartilage and referred through to the back at a point to the left of the vertebral column in the mid-dorsal region; this pain being aggravated by the ingestion of food and relieved by evacuation of the stomach cavity. Hemorrhage, which may appear as a sudden severe hematemesis or simply as a long continued oozing. Vomiting, from one to two hours after taking food, the vomitus consisting of partially digested food and bitter, acid fluid; its expulsion giving relief from pain. Hyper-acidity of the gastric secretion is also given as a constant feature.

Under the light of recent surgical findings, our knowledge regarding the pathology and clinical features of gastric ulcer has been greatly augmented. The weak points have been strengthened and new facts have been brought to light. With regard to the latter it may be said that the present generally accepted view of the clinical picture of gastric ulcer is more or less erroneous and misleading. This is due to two reasons: first, because it has been well established that ulcer can and does exist without any or all or only a few of the cardinal symptoms as above outlined, and second, that if we get a case of ulcer presenting these typical symptoms, it is safe to say that the disease is too far advanced for medical means to produce a permanent cure.

New data obtained reveals the fact that ulcer, though sometimes apparently acute in onset, is really a chronic affection, and but rarely occurs otherwise. In its incipency its symptomatology simulates hyperchlorhydria, and no doubt has been confused with the latter many times. More important still is the fact that when far advanced, it may closely simulate gastric carcinoma, so much so, in fact, that many authorities now agree that ulcer is simply a pre-cancerous state. In corrobora-

tion of this view, we may cite the findings of the Mayo clinic in which a series of cases of cancer showed 71 per cent. to be engrafted on an old ulcer base, while one-half the number of cases in the same series gave a definite history of preceding ulcer.

Hence our ability to diagnose ulcer of the stomach with greater certainty, and at an earlier period than we do at present is of the utmost importance.

The symptoms leading to a correct diagnosis as determined by leading investigators to-day point to certain definite clinical features which are invariably present when the ulcer is located in the pyloric portion or on the lesser curvature. It is conceded that the nearer the site of ulceration is to the cardiac extremity, or if it be on the greater curvature of the stomach, the symptoms are less characteristic and point to an apparently more acute process. But when we consider that the vast majority of ulcers appear in the pyloric portion and on the lesser curvature, this difference does not greatly affect our diagnostic deductions.

In almost every case of peptic ulcer we are able to obtain a history of long standing gastric derangement which has lasted over a period of anywhere from one to twenty years and maybe longer. This disturbance consists of attacks of pain, followed by vomiting, gaseous eructations, and pyrosis. These attacks come on without apparent cause, last a variable period (from one day to several weeks) and then disappear. Every day of the attack is a repetition of the preceding one and usually presents the following symptoms: after a full meal the patient experiences a sensation of comfort which lasts from one to five hours. Then he is troubled with pain, flatulence, sour eructations, and finally vomiting follows, the vomiting usually relieving the pain and distress.

These attacks subside with more or less rapidity and with seemingly as little explanation as they appeared. The patient then enjoys a period of freedom from gastric trouble, which lasts a variable length of time, and during which he apparently enjoys good health. These periods of health between attacks grow gradually shorter and less frequent as time goes on, until such a stage is reached where there is no freedom from symptoms. All the foregoing data may be classed under the heading of "chronicity." Next we will take up the second feature which may be termed "periodicity." This is characterized

by the fact that the pain of ulcer always bears a definite relationship to the ingestion of food. Early in the course of the disease, this usually occurs about four hours after eating, and always occurs at the same time in a given case. The pain really occurs before the ingestion of food, and is relieved by eating, (although the patient believes it to be the reverse). For this reason, the doctor is apt to confuse ulcer in this stage with hyperchlorhydria. In the latter condition, however, there is not the characteristic cycle of gastric attacks with normal health between times as we get with ulcer. These cycles may also be considered as a part of the phase of periodicity of symptoms.

The third and last characteristic feature in our diagnosis, is the manner of control of pain. This is accomplished by (1) vomiting, (2) the taking of food or drink, (3) ingestion of alkaline liquids, (4) lavage. The fact that hyperchlorhydria is accompanied by pain which may be relieved by the ingestion of alkaline drinks may serve to further confuse one in making a diagnosis. But again, we must fall back upon the feature of periodicity to aid us.

When these three great features are definitely determined in a case of gastric disease, it is safe to say that the patient is suffering from ulcer, and if on further investigation we reveal the symptoms of cancer also, we may merely conclude that the cancer is engrafted upon an old ulcer base.

Of course it is admitted that if the ulcer is located in the fundus or near the cardiac extremity of the stomach, these symptoms are less marked.

So also do we find complex phenomena taking place, and equally complex and confusing symptoms arising in the later stages of gastric ulcer, when other pathological changes transpire, such as hour-glass contraction from adhesions, extensive saddle-ulcer, wide destruction of tissue, perforation, adhesions and stenosis, etc. With such conditions present there is usually experienced the most comfort when the stomach is empty. The vomiting is more aggravated and comes at irregular intervals. Gas is present nearly all the time causing great distress, and as the symptoms of stenosis become marked, emaciation results and we are confronted with a very difficult differential diagnosis between ulcer and cancer. The test meal may aid us in so far that typically there is an increase over normal of hydrochloric acid, and an absence of lactic acid, with ulcer.



But it often happens that hydrochloric acid is diminished at this stage of ulcer, and also that the presence of the lactic acid merely speaks for stenosis. In such a case, our only means of deciding for ulcer is the determination of a history of chronicity, etc., as above outlined.

As to the complications that may arise in gastric ulcer the most important is perforation. This is not an infrequent occurrence and is usually chronic in nature. The acute variety is more apt to occur on the anterior wall of the stomach and has a high mortality rate. It is characterized by sharp localized pain in the epigastric region, collapse, and later the symptoms of general peritonitis. Chronic perforation is usually accompanied by the formation of adhesions. If infection occurs in the surrounding area, a localized abscess may form. Sometimes fistulous tracts are formed leading to the liver, pancreas, or other organs. When distortion occurs as the result of adhesions, reduced motility of the stomach is apt to follow. Also an increase in secretory activity takes place, which is followed by a tendency to pyloric spasm, which in turn causes still more increase in gastric secretion. As a result, a vicious circle is formed, all the symptoms are aggravated, and the varied clinical picture which is apt to follow will make the diagnosis a difficult matter.

Hemorrhage is not of so frequent occurrence as formerly thought, according to the latest investigators, although Cabot states that without the vomiting of bright red blood, or else the passage of blood in the stools, the diagnosis is never certain. The blood lost from ulcer is usually vomited unchanged in gross appearance. But here again, in the latter stages of ulcer, where stenosis is present, the blood may assume the "coffee-ground" appearance which is generally believed to be so typical of cancer. When it appears in the feces, blood usually imparts the tar-like appearance to them.

Considering the differential diagnosis of cancer and ulcer, a great deal of the ground has already been covered, and it has been shown how it may be practically impossible to differentiate the two in the latter phases of ulcer. In some cases, the presence of a palpable tumor in the epigastrium may guide us to a diagnosis in favor of cancer, but it must be remembered that adhesions due to ulcer may also produce a palpable tumor though not often is such the case. Cancer is also said to be accompanied by a peculiar mental state of foreboding and a

sense of impending fatality which is absent in ulcer. However, in such cases where it is impossible to come to a definite conclusion in any other way, resort to an exploratory incision is justified, operation in such cases being the patient's only real chance of absolute recovery.

Chronic recurring appendicitis, and chronic gall-stone disease may also simulate ulcer in its phases of periodicity and chronicity, but the pain in the first two is not characterized by the relief from vomiting, alkalis, food, etc., as is that of gastric ulcer.

Other conditions that may be confused with ulcer because of similar gastric manifestations are angina pectoris, the crises of tabes dorsalis, and inter-costal neuralgia. These diseases with the ones already considered are capable of producing pyloric spasm,—an interesting and not fully understood phenomenon, which gives rise to a certain group of symptoms which may mislead one in the diagnosis of gastric ulcer.

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THE SIGNIFICANCE OF BLOOD IN THE STOOLS.—J. M. T. Finney, Baltimore. *Surgery, Gynecology and Obstetrics*, April, 1912. In a recent interesting and instructive article, Finney protests against the prevailing tendency to jump to quick and easy conclusions drawn from certain insufficient clinical data. Laboratory aid should be resorted to in all obscure cases, and, in the opinion of Finney, to fulfill the requirements in the investigation of such cases, "the aid of the despised laboratory man is indispensable." The mere presence of blood in the stools, while not of pathognomonic importance is an otherwise obscure affection, may be of most varied and unusual significance. In general, the great and important group of cases in which blood originates from sources below the cardia of the stomach may be subdivided into several classes, depending upon their pathological basis: 1. Trauma. 2. Disorders of the gastro-intestinal tract proper (a) mechanical disturbances, (b) functional disturbances, (c) inflammatory lesions, (d) new growths, benign and malignant, (e) circulatory disturbances. 3. Bleeding due to some disease of the organs directly connected with the gastro-intestinal tract. 4. Bleeding due to heterogeneous causes as lesions of the blood-vascular system.

It is interesting to note that Finney calls attention to the association of blood in the stool with gall-stones in the gall bladder in cases without the presence of jaundice, ulceration or fistula into the gastro-intestinal tract.

**REMARKS ON THE DIAGNOSIS OF TYPHOID FEVER.**

BY

M. S. BRINGMAN, M. D.

(Read before the Goodno Homœopathic Medical Society, Harrisburg, Pa.)

THESE few remarks will probably fail to do justice to so important a subject as typhoid fever. Nevertheless if they bring out and emphasize a few of the most salient points and lead to some discussion on the topic they will at least attain the object for which they were written.

After giving the definition of typhoid fever, Osler says: "These symptoms are extremely inconstant and even the fever varies in its character. This inconstancy of symptoms leads very frequently to a mistaken diagnosis, as has frequently been exemplified in my limited experience. Some of these cases of typhoid which I remember were diagnosed as pneumonia, meningitis, malaria, appendicitis, bilious remittent fever, and intermittent fever.

In the following only the most important and useful symptoms will be discussed.

Prodromal symptoms. These consist of gradual asthenia, headache, vague pains, nose bleed. All with the exception of nose bleed occur in most acute infections.

The fever.—The characteristic temperature curve described by Wunderlich, rising by steps during the first week, remaining practically continuous for another week or two and defervescence by lysis completed by the end of the third or fourth week is not infallible, and exaggerated diagnostic importance has been attached to this type in the past, for many cases do not conform to this type at all, and often during the latter part of the fastigium, marked diurnal variations of several degrees occur, and some cases of typhoid run their course without a rise of temperature. Bartlett gives the following good and useful rule: "Any fever continuing for a week without any sign of abatement, no matter what its course may have been, will subsequently be proved to be typhoid, providing, of course, there are no physical signs or symptoms to show it otherwise.

Respiratory Symptoms.—Bronchitis is very often present and is made evident by the following symptoms, hurried breathing, slight cough and bronchial rales.



**Circulatory Symptoms.**—During first week there is usually a relatively slow pulse rate as compared to respiration. The dicrotic pulse is a valuable sign, for there is no other acute disease that has a dicrotic pulse associated with it as frequently as typhoid.

**Intestinal Symptoms.**—Intestinal symptoms are very inconstant. In one of the "Johns Hopkins Hospital Reports," of 229 cases of typhoid, there was looseness of the bowels in 76 cases. In 28 of these the discharges were frequent. In 153 cases the bowels were regular or constipated. Tenderness, tympanites and gurgling may be present but are also present in many other conditions. Ulceration of the lymph follicles and swelling of the mesenteric glands are almost invariably present.

The eruption consists of rose-colored spots which disappear on pressure, and usually appear on the abdomen at the end of the first week, but may also appear on the chest, back or other parts of the body. They are often absent in the old or very young.

**Splenic Enlargement.**—The spleen is invariably enlarged, and by the end of the first week the enlargement is evident unless there is great distention of the colon, when the spleen may be pushed far back and difficult to feel. Even the normal area of dullness may not be obtainable.

**Nervous Symptoms.**—In mild cases apathy, headache and slight deafness may be the only mental symptoms. In severe cases there may be photophobia, stupor, muttering delirium, subsultus tendinum, carphologia and coma.

**The Blood.**—The red cells and hemoglobin are reduced, and there is a leukopenia which is an important differentiating diagnostic symptom. The typhoid bacillus may also be obtained from the blood. The Widal reaction is a very important and useful aid in the diagnosis, and as a rule appears before the end of the first week.

The urine is usually albuminous and in about 20 per cent. of cases contains the bacillus typhosus. The "Ehrlich Diazo Reaction" is almost invariably present in the urine by the end of the first week, but also appears in many other conditions.

Therefore, to arrive at a correct diagnosis in many cases of typhoid, we must employ such signs as are invariably present. We know that the typhoid bacillus is always present and can be cultivated from the blood. The Widal reaction is also almost invariably present, and is simple and easy to perform. We

might also make a white blood count knowing that in nearly all other acute infections we have a leucocytosis while in typhoid we have a leucopenia. Typhoid can be differentiated from malaria by examining a stained blood film for the plasmodium of Laveran which is found in "Malaria." The term "Bilious Remittent Fever" is no longer current in modern textbooks; but is still cherished by many practitioners as a waste basket in which to throw every fever which is obscure to them.

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### TONSILLITIS.

BY

WM. JEFFERSON GUERNSEY, M. D., PHILADELPHIA.

(Read before the Hom. Medical Society of the County of Philadelphia.)

THE present trend of medical science is toward the *prevention* of disease and the object of this little paper is to remind homœopathicians that we have the only prophylactic, as well as the only radical cure for, quinsy. Suppurative tonsillitis is an extremely common disorder as well as a tremendously inconvenient one to suffer from, and under the routine treatment of gargling this disease is no more quickly relieved than by the homœopathic remedy and once its invasion is accomplished the honest allopath must admit that his patient is liable to a semi-annual or quarterly recurrence of it. One woman whom I cured of it told me that she had had it all her life and that she had suffered from twelve attacks of it in the three months previous to her coming to me.

There is no need of anyone having more than a third attack of quinsy, even in inveterate cases of it. At least that has been my experience with it. Some cases may be aborted at the first prescription but when this has not been accomplished I have felt perfectly justified in encouraging the patient to believe that the next appearance could be conquered without suppuration and can promise with a fair degree of certainty that if the disease appears again in his or her throat it will be the direct fault of the owner thereof. This is my declaration after thirty-seven years of trial, during the last ten of which I have followed the course to be presently cited. Many of the cases have come to me only for treatment for this disease at first because of knowledge of some other cure, one of the number being an old school physician in active practice who is still pre-

scribing gargles which he doubtless thinks are "good enough for patients" but which he has personally discarded with more or less profanity, and he has acknowledged to me that we have the only cure.

One's first experience with the tonsillitic subject is usually late in the game. The case is generally far advanced as the voice and facial expression indicate: inspection is difficult and conversation painful and annoying: in fact the poor victim is too desperate to willingly submit to interrogation. I have little to say about treatment for patients in that condition except that a poultice on the neck is the only application I allow and that I never open the abscess. I try to find the indication for some remedy but exert most of my efforts in influencing the person to report to me at my first office hour after feeling the slightest soreness in the throat *again*. This I insist upon as well as the avoidance of two fruitful sources of trouble to such patients, namely, wetting of the hair on combing it and dampness of the feet from failure to wear overshoes when needed.

It is with some reluctance that I now come to the particular point of prescribing as I fear that some may disagree with me, and in self defense I will say that I am simply giving voice to my honest opinion and that it is backed by experience and by the verbal and written word of not a few whose veracity is unquestionable.

In treating this disease for the purpose of aborting an attack and of breaking up the habit of its recurrence I have found the high potency and the single dose essential; in fact I have come to the conclusion that if the former is resorted to the latter must be. I do not say that the low potencies will not do as well but that they have not done so for me, and I am convinced that if any failures have resulted with those who have prescribed the higher potencies for this disease it has been from a repetition of them. I am not arbitrarily opposed to the repetition of a remedy in all diseases, indeed in the treatment of skin diseases (in which I have always had more than an ordinary interest) I frequently give the medicine continuously. But with some throat affections I know that one must wait if a high potency has been exhibited or the case will be spoiled. This is not theory alone for I have experimented considerably along this line and I assert most emphatically that I have had the best results when I have given the selected rem-



edy high and have waited on the action of a single dose, indeed it is common to find an aggravation from this single dose within the first twenty-four hours so that one might readily conclude that it was failing to act unless a further delay was followed by a corresponding improvement. For this reason I have made it an invariable rule to wait fully two days in every case before considering either a repetition or change of remedy. Not long ago I prescribed one powder of *lycopodium* CM for a right-sided, ulcerative tonsillitis and the next morning the entire throat was one mass of ulceration. Indeed, it had assumed a most alarming appearance and if it had not been for the rule just mentioned I should have spoiled the case by meddling some prescribing. Some previous experiences came to my mind and I decided to wait one day longer. The next morning I found some improvement and by the following day a wonderful change for the better.

In order to condense this statement as much as possible I will say that three remedies have cured the most of my cases: *lac caninum* CM (Swan), *lachesis* CM (Fincke) and *lycopodium* CM (Skinner). The differential indication for these remedies is chiefly one of location. For those that are upon the left side, or that have commenced on that side and gone to the other, *lachesis* should be selected; for those of the reverse order, *lycopodium*. For those that had soreness upon either side and had gone to the opposite tonsil and later returned (during the same attack) to the original side, or in any way showed a tendency to alternate from side to side without any preference to either, *lac caninum* is assuredly the remedy. Another indication for this remedy for any throat affection is when the subjective and objective symptoms are upon opposite sides. I do not remember to have seen this in any book but have found it a good indication for the medicine. Again, if small follicular ulcerations appear upon either tonsil I would think strongly of *lac caninum*.

The virulence of the snake poison has always been an endorsement for its medicinal properties: the worthlessness of a powder that was so inert as to have been used solely for dusting pills was at first ridiculed; the very thought of employing dog's milk as a medicine appeared absurd on the face of it. We have however learned to judge a medicine by its power to produce symptoms in the well and to take that as our sole evidence of

ability to cure, and many remedies of the humblest origin have gained an exalted place in our armamentarium.

In regard to the value of location as a guide in prescribing I wish to quote from a little book on diphtheria by the late Rollin R. Gregg: "Should there be those who will think it trifling with human life to rely upon the sole distinction as to which side of the pharynx diphtheria commences, as the principal guide to treatment in so grave a disease, all such are respectfully reminded that *nature* begins two-thirds or more of all cases in that way, and nature never trifles."

After an acute attack of tonsillitis has been treated and a second one aborted it is well to consider the susceptibility of the patient to colds and the possible aggravating conditions of his or her occupation, and it may be best to follow up the treatment by baryta carb., which I invariably use in the 50m potency and in that case give it continuously about once a day for several weeks, or, in other cases, once a week for several months. Just why a remedy should be repeated to protect against a condition which does not yet exist and why it should not be repeated when it is evidently there is a problem, but I am merely giving experiences which may or may not be helpful to others.

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## THE VALUE OF HOMŒOPATHIC REMEDIES IN POST-OPERATIVE CASES.

BY

J. H. MCCLELLAND, M. D., PITTSBURGH.

(Read before the American Institute of Homoeopathy, June, 1912.)

IN this brief note I will endeavor to give my experience as to the value of homœopathic treatment in post-operative cases and will indicate some of the remedies I have used to advantage.

I cannot express my opinion in brief better than to quote a paragraph from the very excellent paper read by Dr. James W. Ward at the International Congress of 1906. He says, "I am truly sorry for that surgeon who has not tapped the vast storehouse of our remedies to make more resplendent the result of his surgical endeavor."

I am equally pained when I hear clever surgeons assert that they know nothing about medical treatment.

It was an ancient Hindu practitioner, Susruta, I believe,

who said, "A physician who is not a surgeon and a surgeon who is not a physician is like a bird with one wing." This is emphatically true of the latter—a surgeon should certainly be a physician. Medicine does relieve much distress and suffering following operations and not infrequently averts impending disaster.

Is there any logical reason why medicines, and especially homœopathic medicines, should not be effective for morbid conditions following operations? I can think of none.

Admitting that much of the distress following operations is owing to the narcotic effect of the anæsthesia, have we no means to hasten the recovery from these effects?

Undoubtedly we may answer in the affirmative, and my own experience of two-score years or more justifies a very emphatic affirmation, in almost all forms of post-operative affections.

I am quite free to admit that there are some post-operative conditions quite out of the sphere of medication, but these are not in the majority.

While specifying some of the more useful remedies, it is not the purpose of this paper to exclude a consideration of many others that may be required in given cases.

*Shock*.—The amount of shock depends upon several factors and these must be taken into account. Whether there can be an easy distinction between shock and collapse is problematical.

Taking the cause or causes as a factor the symptoms or conditions will determine the treatment.

Whether there has been excessive loss of blood, a great amount of traumatism either in accident cases or a much handling of tissues during an operation,—whether there has been long exposure of important cavities or whether there has been severe mental strain, all have a bearing on the treatment.

I may here give the standing orders that as a rule govern my hospital practice, in serious post-operative cases:

*Camphor*.—When the patient comes down from the operating room she (or he) receives three doses of camphor 1x, three drops, at intervals of fifteen minutes, provided there is sub-temperature and the blood pressure is low.

*Veratrum Album*.—If reaction is not prompt the camphor is followed by veratrum album 3x, three drops every hour or half hour until the temperature reaches normal. This is particularly called for by the usual symptoms of cold sweat, etc.

*Cuprum Arsenicosum*.—When the temperature reaches nor-



mal and nausea and vomiting develops with thirst and pain, cuprum ars. 6x is given three drops hourly until relieved.

*Nux Vomica*.—If there is simply nausea and disgust for food as a result of the anæsthetic, nux vom. 3x is given hourly until relief.

If nausea continues unduly, choice is made from the following: Apomorphia 3tr., ipec. 3x or tart. emet. 6x.

*Arnica*.—For trauma. If there has been undue handling of tissues, as in abdominal cases at times, great relief from the ensuing soreness is obtained from the exhibition of arnica 3 to 6 two or three hourly, and I have been led to believe we may thus avoid further trouble.

*Belladonna*.—After operations there is at times a reactionary temperature, with great tenderness in and about the part, with flushed face, headache, etc., then belladonna brings great relief.

*Bryonia*.—If the tenderness is not quite so acute, but there is much soreness locally and all over, with coated tongue and thirst, bryonia is very effective.

Peritonitis or pleuritic invasion is often cleared up by the use of bryonia.

Not infrequently dysuria follows an operation, especially an abdominal one, and is often relieved by hyoscyamus; or, if there is anuria, canth. or terebinth according to their well known indications.

A most troublesome complication after abdominal operations is flatulence or meteorism. Raphanus is an excellent remedy, but there are many others. Nux vom. 1x will sometimes cause expulsion of the gas, but we have magnes. phos., colo., asaf. and many others.

For a general febrile condition we have the old tried remedies, such as aconite, ferrum phos., etc.

For septic absorption with church spire temperature chart, much can be gained by the use of chin. ars. 3tr. three grains every two hours.

For phlebitis, the sheet anchor, I believe, is hamamelis internally and externally—a case may require bell., puls., rhus., or lachesis, according to indications.

It goes without saying that as homœopathic practitioners, we may call into service any remedy in the *Materia Medica* for which we have clearly defined indications.

**THE VALUE OF HOMŒOPATHIC REMEDIES IN DISEASES OF THE HEART AND LUNGS.**

BY

HERBERT C. CLAPP, M. D., BOSTON.

(Read before the American Institute of Homoeopathy, June, 1912.)

WHEN I was urged by the chairman of the Bureau of Materia Medica to give my testimony as to the efficacy, or otherwise, of the indicated homœopathic remedy in diseases of the lungs and heart, I understood that no learned dissertation going into the minute details of the subject was expected or desired. Such an essay might easily fill a book, but would find few listeners or readers, no matter how well it might be prepared. I imagine rather that what is wanted in this symposium is a brief practical statement of convictions.

First, then, I still continue to believe in homœopathy as being very valuable in the treatment of chest diseases. Not that it is absolutely infallible, and not that I invariably use it to the exclusion of everything else. The broad and liberal motto adopted years ago by this Institute I welcome with joy, and yet I exceedingly dislike to see this liberty degenerate into license, as I am afraid it does sometimes. For instance, a lady whom I recently examined, and who came from a New England country town, told me that when she went there she sent for a certain physician by the advice of friends, and that after he had prescribed for her for about a month, she incidentally remarked to him that she had always previously employed a homœopathic physician, and would have preferred one now. but understood that there was no one in town. Whereupon he said, "Why, I am a homœopathic physician." The commentary is: How could he have concealed the fact so long, and yet have been one? Perhaps something like this may be the explanation: A new family had moved to town. The minister, anxious for additions to his church, meeting the boy of the family asked if his father were a Christian. The boy answered, "Yes, but I guess he doesn't do much at it nowadays."

I estimate that at least 19 out of 20 of my prescriptions, and perhaps more, are as nearly strictly homœopathic as I know how to make them, and they are confined to the regularly prepared attenuations. Most of my departures from the homœopathic law will be suggested in the course of this paper. I be-

lieve that the better posted we are on the action of drugs, and the more we know about hygienic and dietetic management, the less need there is to depart from similia. When we do depart from it, there should be a very good reason. We should desire and expect to obtain some definite and tangible result which may not always follow the attenuated prescription. For instance, in a case of broken compensation of the cardiac muscle which has not been restored by the homœopathic remedy in conjunction with proper rest, we may desire to give the fat-free tincture of digitalis in 5 or 10 drop doses, or even the infusion. This, if properly chosen, will give fairly uniform, definite and tangible results, wholly irrespective of the color and taste of the drug. How different is this principle from that which at times tempts us to toady to the desires of a patient who hankers after the fleshpots of Egypt, and who clamors for medicine with some "strength" to it, by giving him some highly colored and flavored, and perhaps nauseating compound in a big bottle, the only genuine effect of which is on the imagination? For the old school pharmacopeia, I know by experience, is full of compounds which thus make a strong appeal to the minds of certain classes of patients, and which are comparatively innocuous, if not inert, to say nothing of those which also tend to upset the digestive or other functions. For which reason it seems absurd for regular physicians to assume a tone of superiority in their claim that homœopathic remedies act only through the imagination. One of such preparations which physicians of almost all kinds prescribe, mainly in deference to the demands of their patients, or merely for the sake of "doing something" is the compound syrup of hypophosphites. When it does exercise a so-called tonic or bracing effect, it is due to the strychnia which it often contains. If this drug is desirable, it is much better to give it alone, in a small tablet in the same dose, 1-60 of a grain. All the virtues of the hypophosphites without the strychnia can just as well be secured without the frequent gastric weakening, by the homœopathic attenuation of the drug. Patients should be taught and can be taught that the virtues of a drug do not depend on its color or taste, or always on the size of the dose, and therefore that they themselves should not be foolishly imaginative. This may apply to some of our own members, who have not faith to remove mountains, as well as to patients, as shown in the strong coloring in the tinctures in their pocket cases, not of



powerful drugs, but of those which our regular friends would consider practically inert. Really, how much more medicinal effect is derived from 10 to 15 drops of the crude tincture of puls. or cham. in half a tumbler of water, a teaspoonful every hour, than from the third decimal dilution of the same, outside of the possible psychic influence?

If the physician desires, in treating a cough so violent that the patient declares he almost "coughs his head off," to prescribe heroin, which I occasionally consider very commendable, if not carried too far, how much better it is to hand him a small vial containing a few tablets of the 1-24 of a grain, rather than to write for him a prescription containing the same drug mixed with the syrup of tolu, or other voluminous padding? You thus not only keep things in your own hands, and prevent him from repeating the prescription when it may be to his injury, but also partially educate him in the efficacy and superiority of the small dose, which is a valuable asset to him when you wish to prescribe an attenuation, as you certainly far oftener do.

To illustrate another phase of the subject: Many years ago I was called to attend a lady who was terribly afflicted with asthma. In spite of my best efforts and hard study over the case, I was able to do her little, if any good, but still she clung to me until I felt ashamed to go there, and told her so. (In contrast, how often by a mere whim the physician is discharged, when he is really doing as well for the patient as anyone could do, if not better.) She, then, in desperation, bought for \$3.00 a bottle of a proprietary medicine, looking and smelling like tar, which nevertheless practically raised her from the lowest depths of despair into the seventh heavens of beatitude, and which made of her a new woman. She kindly gave me some, and I took it to a chemist and had it analyzed. Barring the padding which was made to appeal to the senses as a source of power, it consisted wholly of the iodide of potassium. Since that time I have made a great many people very happy by giving them five grains of that drug, simply dissolved in five ounces of water, one, two or three times a day, as long as seemed to be wise, in conjunction with the indicated homœopathic remedy. And I am convinced from a large experience in this treatment with and without the homœopathic remedy, that the latter is not simply a placebo, but that it adds to the effect of the crude drug, and, when a cure is possible, does even

more than that in the attainment of this object. When suddenly called to an intense paroxysm of asthma, with sufferings which will not wait for slower action, I often prescribe as an immediate palliative the inhalation of the fumes of one of the stramonium powders or amyl nitrite. This is on the same humanitarian principle that induces a physician to give a hypodermic of morphine during the passage of a gall stone. Not many physicians are so completely wedded to pure homœopathy, that they would refuse a patient this consolation, particularly if they had ever passed gall stones themselves. If they do object to such treatment, why should they not logically object to etherization before a surgical operation? But the judicious and semi-occasional use of morphine is vastly different from the habit of some physicians, of throwing it in carelessly whenever the patient mentions the word pain. For, not to speak of the danger of forming the habit, it is sometimes positively and immediately dangerous to life, as for instance in the treatment of acute pneumonia, where many of the standard regular text-books still continue to recommend it for the alleviation of pain, insomnia, restlessness, etc., in spite of the wise cautions of some of the best of their own confreres in this country and abroad, who freely denounce it as dangerous to the centers of respiration. Sometimes this pain and consequent sleeplessness in pneumonia is so distressing that we are tempted, if we do not want to use morphia, to use the coal tar products to secure quick relief. But in a disease where heart failure is so often the precursor of death, it is no wonder that many of us shrink from assuming such a risk, especially as we have other and safer means of alleviation at hand, even if their action is not so rapid.

In the treatment of hemoptysis, I believe that nothing is more efficacious than the homœopathic dilutions. Some years ago I read before a medical society a paper which was afterwards published in the *N. E. Medical Gazette* for July, 1898, advocating this proposition, and quoting largely from the writings of the leaders of the allopathic profession, who exposed the inefficiency or the unscientific character of many of their commonest prescriptions for this symptom.

We all agree that fads affect the doctor as well as the dress-maker. For some years the old school has pushed the creosote treatment for pulmonary tuberculosis to the front to the extent that some have seemed to think that a patient had been

neglected or maltreated whose breath was not rank with the odor of it, and some of our men also have felt themselves forced into line. I never could see any good in it, and often harm. Now, in the best places, it is rapidly going out of fashion.

After abundant opportunities for observation, I am very sure that in the treatment of pulmonary tuberculosis, especially with our modern hygienic measures added, our homœopathic remedies are decidedly superior to those of the old school. This is not simply an opinion, but it has actually been conclusively demonstrated statistically from an analysis of 6,000 cases of the disease treated at the Massachusetts State Sanatorium at Rutland, Mass., during a period of 11½ years, beginning in October, 1898. Both the regular and homœopathic schools were represented in this institution, the homœopathic patients constituting about four-ninths of the whole number for the first few years, and latterly about one-third. Every single thing, excepting the medication, was exactly the same for both services: the climate, buildings, food, water, discipline, exercise, rest, amusements, etc., and the patients were not segregated into two groups, but were assigned to beds just as they happened to enter. For the first few years Dr. Fred'k B. Percy was the homœopathic member of the board of trustees, appointed by the Governor, and on his resignation he was succeeded by Dr. John P. Rand. Dr. Bowditch and the writer were appointed as visiting physicians, to have the supervisory charge of the treatment on the two sides respectively. The first resident physician on the homœopathic side was the late Dr. D. P. Butler, who after two years was succeeded by Dr. George N. Lapham, who then served for almost ten years. My own term of service covered about nine years from the opening of the institution. The prescribing on our side during the period covered by the report represented fairly well, I think, that of the average homœopathic physician. At any rate, at least 19 out of 20 prescriptions could be called homœopathic. The statistical classification of cases was somewhat complicated, and unfortunately for a clear, rapid presentation was made on one basis for the first eight years, and on another for the following 3½ years, the whole needing some little study for an accurate comprehension. If anyone would like to make this study, he is referred to an article by the writer, going into the matter in considerable detail, which was published in the *N. E. Medical Gazette* for April, 1911. The statistics there pub-



lished were all carefully compiled from the official records of the State Institution. In brief, and as a summary, it may be said, that during the first eight years under the so-called "Rutland" Classification (this being the first State Institution of its kind in the country) 66 per cent. of incipient cases under the "Regular" treatment were "apparently cured," and 69 per cent. under the homœopathic. During the following 3½ years under the so-called "National Association" classification, 80 per cent. of incipient cases under the "Regular" treatment were either "apparently cured" or "arrested," and 87 per cent. under the homœopathic.

Of course it is ridiculous to try to draw conclusions from statistics from a dozen cases of any one disease, or two dozen, or fifty, or even one hundred, but when you can assemble an immense number like 6,000 cases in one institution under exactly the same surroundings, statistics under these circumstances certainly mean something. What wonder is it that after considering such statistics my faith in the value of homœopathic remedies in diseases of the heart and lungs should be strengthened.

A few copies of the reprint of the *Gazette* statistical article referred to are still on hand, and will be sent on application.

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THE DOCTOR'S DECALOG.—I. Don't waste your time. Be doing something every minute.

2. Strive to make a good impression. Dress well. Learn to talk well. Be a man among men.

3. Be a courteous professional gentleman, but also a square-deal-giving and a square-deal-demanding business man.

4. Buy books. Subscribe for the journals, and write for them. Attend the societies, and let your voice be heard.

5. Equip yourself with every material thing that will increase your diagnostic and therapeutic power.

6. Don't be ashamed to consult with other men. Give them of your knowledge, and extract from them every fact of possible value to you.

7. Be a real and not a pseudo investigator. Take nothing on faith, but refuse nothing because it is condemned.

8. Make every case a subject for real research work, and leave no fact concerning it unknown that is capable of being uncovered.

9. Shun quackery as you would poison; but ascertain its sources of strength, adding the latter to your store.

10. Wear no man's collar. Let truth, honor and manhood be your only masters.

**THE HOMŒOPATHIC PHYSICIAN OF TO-DAY.**

BY

JOS. P. COBB, M. D., CHICAGO.

(Read before the American Institute of Homœopathy, June, 1912.)

THE title of my essay might be construed to indicate a discussion of a variety of different things. I take it, however, that our chairman desires a discussion of what a homœopathic physician of to-day ought to be and shall so limit myself.

It is sometimes useful to try to see ourselves as others see us. Our friends, the enemy, of the dominant school of medicine, claim that there are no real homœopaths to-day, or so few that they are a negligible quantity. They would rule out of our school, all of those who apply the teachings of modern science to the practice of medicine; all who use any kind of adjuvant treatment; all who use any antiseptic or aseptic measures or precautions; all who rely upon surgical intervention for any diseased condition; in short, all physicians who do not believe in the universal efficacy of the potentized remedy and who do not confine themselves solely to the use of the infinitesimal dose.

To them this body has tersely replied in its definition of a homœopathic physician, viz.: "A homœopathic physician is one who adds to his knowledge of medicine a special knowledge of homœopathic therapeutics and observes the law of similia. All that pertains to the great field of medical learning is his, by tradition, by inheritance, by right." (Eugene H. Porter, M. D., Secretary.) If we could rest our case here, our reply would be unanswerable. Unfortunately, our friends reply that there is a class that their limitations correctly define. To some of us their rejoinder does not seem to diverge very far from the truth.

At the outset of our self inspection we are forced to admit that we are not a homogeneous body, that we do not all stand upon the same platform; that there are more differences in our teachings and practice than can be explained by the individual personal equation.

In a broad sense we may divide ourselves into three groups. One group, comparatively small in numbers, can be fairly described by the limitations our friends in the dominant school would set up as the definition of a homœopath. This group of ultra homœopaths, styling themselves homœopathicians, ap-

pear to demand the same standard with the same limitations as their measure of a homœopath: for them science as applied to the art of medical practice halted when Hahnemann died.

The "law of similia," the fruit of the deepest insight into science in 1810, an inspiration of the leading scientific mind of that age; a law that the scientific knowledge of Hahnemann could not prove except by accumulated clinical evidence (which is a support but not a proof), a law which Hahnemann's contemporaries could not accept because they could not understand, a law they could not disprove, only ridicule, inveigh against its application by attacking the vulnerable points in Hahnemann's theories and deductions, setting a narrow, selfish, unscientific example which their successors in the dominant school of medicine have been contented to follow down through the decades until quite recently; such a law inspiring such opposition, so poorly understood, yet underlying the art of medical practice in every school, in every individual practitioner's work, underlying every theory of practice which stands the test of clinical use; such a law, our friends the homœopaths, seem to say needs no scientific proof, only the corroboration of accumulated clinical observations; observations often only partly made, incorrectly interpreted and imperfectly recorded.

If we had all been bounded by these limitations, how many would we now number? What influence would we carry to-day? What right would we have to ask for support?

Another group, probably more numerous, standing at the opposite extremity from the homœopaths are more difficult to understand or to define; they are of us, but not with us.

To their patrons they are known as homœopaths, but they take no interest in homœopathic organizations or institutions; when they join societies, they usually join what they call the regular societies; in directories they often put the cabalistic *R* after their names. To them the *Organon* is all "Tommyrot." They never understood the meaning of "*Similia similibus curantur*," and consequently find little interest or success in trying to work under its guidance.

They want specifics; they are looking for something new; they are enthusiastic over the latest synthetical compound to the extent that every patient receives it to-day; to-morrow they are "off with the old and on with the new"; they add nothing to the common fund of knowledge and experience;



their horizon is narrow and they grow narrow; they owe nothing to the school, to their alma mater, or to the community in which they live, but the world owes *them* a living which they reach out for.

They see no reason for the maintenance of a separate school or organization; they think the millennium is coming so quickly that they must needs hurry to get into the bandwagon.

How many there are whom some of these charges fit I do not know; probably few of those so described would admit any accuracy in my description, yet I leave it to you if such do not exist. Unlike the homœopaths they have not the strength of their convictions, they take no positive stand, they are working for individual ends, not for principles.

If such a class exists, to what extent do they help in popularizing homœopathy, in exemplifying the law of similia or in convincing our opponents that we have something that they need?

I find no difficulty in turning from these groups to picture what I hope is the largest group in our school of medicine. Men who believe that Hahnemann was the greatest thinker of his age, who believe that he was the instrument for enunciating one of Nature's laws, just as Newton was for enunciating another of Nature's laws; who believe that he will stand out in all ages as a shining example of what a physician ought to be; who believe that everything that was true in Hahnemann's teaching one hundred years ago is true to-day; who believe that if Hahnemann were with us to-day, he would be a leader now as he was then, that he would master the scientific knowledge of to-day as he did in his own time, that he would modify some of his theories in the light of to-day, that he would test them all as he did then by every known scientific test.

Do you think that anyone would have been more keen than he in using the knowledge of to-day in developing preventive medicine? Would not modern sanitation appeal to such a mind? Do you think that he would turn down the theory of immunization without personally investigating it? Would he not change his language and his arguments in explaining the action of remedies if he were writing to-day? Can you imagine that he would be content to have his theories proven by his opponents without any help on his own part? His devotion to the truth would make him welcome the researches of others, but they would stimulate him also. The true disciples of Hahne-

mann are not those who protest the most. The real homœopath is not an idealistic one-sided enthusiast, but an ardent student of everything that pertains to the science as well as the art of medicine. He does not measure everything by his standard, but tries to measure his standard by the accumulated knowledge of the world.

In this group I believe the majority of our school are willing and proud to class themselves. Here I believe will be found the men and women who work in our societies; who contribute of their time, of their brains and of their money to support our organizations and our schools; who believe that **not** yet is it time to relinquish our efforts for the maintenance of a separate school of medicine.

I would summarize my ideas of a homœopathic physician as follows:

1. A homœopathic physician should be a gentleman and gentlemanly under all conditions: some of us are not.

2. A homœopathic physician should be a physician and not a "commercial doctor"; he should always consider the patient's interest as his first interest: some of us do not.

3. A homœopathic physician should try to acquire a usable knowledge of the science upon which the practice of medicine rests and to apply that knowledge in his practice: some of us do not.

4. A homœopathic physician should try to understand the meaning of the law of similia, to appreciate its value, to apprehend where it is applicable as well as where it is inapplicable: some of us do not.

5. A homœopathic physician should remember that gross polypharmaceutical prescribing is always antagonistic to the law of similia: apparently some of us do not.

6. A homœopathic physician should not promise to cure the incurable, should not claim to have cured incurable conditions, should never argue as if "post hoc were propter hoc," should never make ridiculous, illogical and inaccurate statements. But we do all of these things.

7. A homœopathic physician should have the strength of his convictions; should be proud of the fact that he knows how to apply the law of similia; should always be ready to explain its application either in the abstract or in a concrete case; and should hold himself to its observance.

How often we fail!

**THE TREATMENT OF NERVOUS AND MENTAL DISEASES BY OCCUPATIONAL METHODS.**

BY

EDWARD A. EVERETT, M. D., BELLE MEAD, N. J.

(Presented at the 1912 Meeting of the American Institute of Homœopathy.)

WHAT to do for the idleness and misdirected energy of insane and nervous patients is a problem that has long confronted both alienist and neurologist and has taxed to the utmost the patience and ingenuity of both. To those to whose care the insane and nervous are intrusted the matter is one of considerable importance both from therapeutic and economic standpoints. How to relieve the tedium and monotony of long periods of enforced confinement and transform valuable energy misspent in useless activity into productive occupation well merits our serious consideration. To combat the pernicious effects of this inertia and wasted energy, work in its various forms is employed.

Referring briefly to the history of the subject we find that it first received attention at the colony of Gheel, Belgium. Gheel first became known outside of its own locality in the eighteenth century. Of its early history a prominent alienist has written: "The colony of Gheel is so old as to have its origin shrouded in the mystery of miracle and superstition." Scotland has had for over fifty years a system somewhat like that in vogue at Gheel. I refer to the well known Scotch "family care." Germany has been represented by Bethel near Bielefeld since 1867. For some time France and Switzerland have treated the matter along similar lines with success. In the United States many State hospitals for the insane, notably, Middletown, Gowanda, Manhattan State, Central Islip, Rochester, Utica, and several State institutions for epileptic patients, such as, Skillman, N. J., Craig Colony, N. Y., and the institution at Gallipolis, Ohio, have been measurably successful in working out the problem. Private institutions likewise have given the matter some attention.

From a therapeutic point of view patients who are able and are more or less willing to work should be encouraged to do so. This admits of no argument. To consider the matter from an



economic angle. Surely in these days of conservation it behooves us to reduce the cost of maintenance as much as possible by any legitimate means within our reach. If a two-fold result can be obtained the importance of the subject can not be denied.

Work indoor and outdoor; both manual and mental are employed. Farming, shop-work, (arts and crafts and sloyd), domestic work, and office work are the principal varieties used. It is self-evident that a careful supervision and intelligent choice of attendants, or teachers, is necessary. In the selection of work where the aesthetic and utilitarian are combined the best results are obtained, if a therapeutic goal is sought. The ideal form of occupation is work on the farm, and in the garden. Next desirable is employment in the shop or household. Experience has taught us that patients in the class under consideration are benefited when they are made to live outdoors as much as possible.

A very practical demonstration of this point can be obtained by an experiment with the restless, disturbed, and filthy insane. If kept indoors they become disgruntled, faultfinding, chafe under the restraint and when at all so inclined, resort to filthy habits. Put these same patients outdoors and keep them out all day, if possible, giving those in any way fit, some form of occupation, and the result is in most cases surprising. They will not complain so much. The untidy and filthy will improve in their habits and a more contented and interested feeling will prevail. The writer has seen this demonstrated time and again.

Dr. Rowe, whose opinion is based upon considerable experience states: "Case after case have I found showing improvement due to regular occupation and ideal conditions in farm and shops . . . slow parting with morbid introspection, and long-held delusions, and gradual illumination of the old brain and waking up to responsibility."

Plenty of land should be used. The consensus of opinion is that one acre to a patient is the best allotment. Frequent periods of rest are necessary. The assignment of work should not be determined until a careful study is made of each individual patient both as to his disease and as to his physical condition. With routine methods installed orderly conduct and orderly thinking result.

If a patient gets only custodial care he will vegetate and his mind will all the more quickly deteriorate. This especially

applies to that large class—the psychoses incident to the evolutionary period of life (dementia præcox, etc.). Diefendorf, in the 1907 edition of his well known work, states: “An essential feature of the care of these mental shipwrecks is healthful employment, preferably out of doors.” This statement is made in connection with the treatment of dementia præcox.

The occupational methods here alluded to are very closely allied to the “after-care” of the insane and neurotic now so strongly advocated and used all over the world especially in New York, France, Germany, England, Japan, etc. Combined with suitable employment there should be proper amusements such as bowling, tennis, baseball, billiards, field sports, etc.

To show the results obtained I will refer to the following synopses from the histories of a few cases: A woman, middle-aged, depressed, restless and destructive, after being persuaded to do some basket weaving was finally helped very much. Her restlessness and destructive tendencies disappeared and with their going there was noted a more hopeful spirit. She ultimately recovered and returned home. This happy end was not reached, however, until a great deal of patient effort on the part of the teacher was expended. At first it was disheartening to try to interest the patient. Persistent and kind but firm direction won her over.

A young woman with hypomaniacal symptoms accompanied by the usual playful, saucy, and mischievous attitude was finally induced to do raffia work. She gradually became interested and as she did, she became more subject to discipline. The mischievousness lessened, the saucy and impertinent manner became modified, and she showed more self-control. She left the care of the teacher before she recovered, hence the final outcome is not known.

An irascible and restless old man (arterio-sclerosis) under the guidance of the teacher took up wood carving and became so interested that his whole attitude changed. He became enthusiastic and entered into the work with zeal. It improved his mental condition very much.

A woman, middle-aged, depressed, restless, and given to self-mutilation, (biting and tearing flesh from her fingers) resorted to this less and less as she came under the influence of the work (basket making).

A preoccupied young woman inclined to depressive ideas and abnormal thoughts of her own unworthiness finally entered into

the spirit of the work room and gradually gave up her morbid tendencies.

A young man in the early stage of dementia præcox seemed to improve after being initiated into the routine of the shop. His introspection and listlessness altered and the methodical, systematic work given to him certainly helped to keep his mind from a more rapid deterioration.

A demented, middle-aged man has for years been more contented and happy in doing certain household duties with clock-like regularity. When at times forced to give up his work temporarily he would become restless and irritable. A resumption of work would correct this condition.

A young woman who was quite rapidly becoming depressed and introspective to an alarming degree, with vague ideas of suicide, recovered under the tuition of the teacher. She, being a stenographer, was given office work besides work in the shop. Of course her recovery was not due alone to this method. She had the advantages that are common to the conduct of a well-ordered institution.

Several patients in the demented class (chronic cases) certainly were helped by outdoor employment on farm and in garden.

Physicians wishing to treat successfully nervous and mental diseases can not ignore occupational methods. They are as necessary as other auxiliaries, such as electricity, hydrotherapy, massage, etc. They certainly deserve a place in the broad field of therapeutics along with other drugless procedures.

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Dr. S. D. Sauer recommends *Melilotus* 3x highly in facial neuralgia.—*April Century*.

COCCULUS 3.—Will often prevent sickness from riding in a railway train; it should be taken for a few hours previous to the journey by those predisposed.

PHOSPHORUS 6.—A most remarkable remedy for nausea in a feeble stomach, especially morning nausea.



**ETHICS.**

BY

P. A. NOLL, M. D.

(Read before the Goodno Medical Society, York, Pa., June 13, 1912.)

THE term "Ethics" implies the principles of the Golden Rule and may, therefore, be employed in all walks of life and in all transactions or relations in which a physician may be concerned. I shall endeavor to confine myself merely to the discussion of that part which deals with the relationship of physicians in competition with each other in the same localities.

That this is still a distinctly competitive age among physicians, remains an indisputable fact despite the remarkable progress made in commercial circles toward obliterating the competitive features which have been found most detrimental to their pecuniary advancement. This may be to the credit or to the discredit of the profession in general, according to the viewpoint from which our individual success or failure in practice is estimated. Certain it is that a community will judge a practitioner's standard of professional competency by his apparent financial prosperity, and in this manner place him upon an equal footing with the merchant whose business methods are vastly different and are unrestricted by the principles of ethics observed by the conscientious physician. Here we are immediately placed at an apparent disadvantage because the merchant who, by advertisement or other means, can convince the public of the superiority of his business, will be the leading man in his line. Not so with the physician, especially in a new location. He has to contend with all the disadvantages associated with his position in a defenceless manner. He has nothing to his credit to begin with and has to overcome all the prejudices of a biased public. In spite of his qualifications it remains for a community of farmers and mechanics to determine whether he really knows anything before they engage him, and this only occurs in cases when the services of the previously established family physician cannot be obtained or where the prospects of remuneration are decidedly slim.

Unfortunately, the new man in town who can least afford it must bear the brunt of unremunerative work, which may be of a deserving or undeserving nature according to the merits of the case. Of course he is told that good results in that line

will determine his engagement by affluent friends and relatives and thus gradually enable him to establish a remunerative practice. Be this as it may, I do not advocate the policy that the poor keep the poor, but would suggest legislation by which their professional needs would be supplied and the physician's fee guaranteed by the state. Happy, then, to contemplate is the fact that with all the trials of a beginner, the code of ethics if properly observed by all parties concerned, will tend to serve as a go-between and successful arbiter of all difficulties which may arise during a competitive system of practice. It makes the united efforts of the competitors co-operative for the benefit of the patient and thus distinguishes the medical profession and elevates it to a higher ethical standard than that of any other calling. For this reason I would deplore the adoption by the profession of advertising methods as recently advocated by one of the leading dailies of our state. It would destroy the best safeguard against that element of practitioners who would completely commercialize the profession and would give the most prominent rank to those investing the largest amount of money in advertisements, hence the attitude of the press in this matter can be easily understood.

We find it very trying at times to maintain a strictly ethical attitude, especially when reports of adverse criticism by fellow practitioners are brought to us. But we must not overlook the fact that the informant may possibly have some sinister motive for his actions and besides may not be telling the truth. It is best to ignore doubtful information, but, if the source is reliable, a personal interview diplomatically conducted, will oftentimes re-establish perfect harmony and eliminate all misunderstanding. It is surprising to find how many good qualities the other fellow really has after you become better acquainted with him. Of course, no code of ethics can entirely obliterate our competitive instinct but it certainly is not necessary to resort to the one time customary poisoning argument against the old school because they have practically acknowledged their fault in that respect and have made heroic efforts to overcome them. Neither do they any longer annoy us by devouring the entire supply of remedies left by us when a change of physicians is made. I distinctly remember an instance which occurred in my early boyhood during the illness of an older brother, and the moral effect of which seemed to

convince my parents for a long time that medicine which does not kill will not cure.

When called in consultation with a member of the old school, I have found it expedient to compromise in his favor as much as I conscientiously could in regard to treatment, and, if necessary, by insisting in a mild but firm manner and I have always managed to obtain the same consideration from my old school consultants.

When we consider the cruel nature of our present-day competitive system in the commercial world, we can hardly refrain from feeling somewhat out of place with our little code of ethics and will sometimes insist that one of our fellow practitioners has "done gone and stolen" one of our best patients. Be it remembered, however, that the first patient who was unwilling has yet to be stolen, and the practitioner in a new location, with keen competition, has practically nothing else left to do but this particular kind of thievery. I believe, however, that we are going on to a greater future in all walks of life, and that in the course of a few years the principles of ethics, which at present seem most inconsistent from a competitive viewpoint, will be universally approved under more economical conditions and that the medical profession will receive credit for having perpetuated them against seemingly insurmountable odds.

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### A STUDY OF HYDRASTIS.

BY

F. P. MCKINSTRY, M. D., WASHINGTON, N. J.

(Read before the New Jersey Homœopathic Medical Society.)

CHIEF Synonym—Golden Seal. The Pharmacopeia of the American Institute of Homœopathy gives thirteen other synonyms as follows: Eye balm, ground raspberry, Indian dye, Indian plant, Indian tumeric, Ohio curcuma, orange root, yellow eye root, yellow paint, yellow puccoon, yellow root and yellow seal. Lloyd adds still another, jaundice root. Natural order, Ranunculacæ; habitat, Canada and the United States east of the Mississippi River.

Hydrastis is "a deciduous perennial herb having a thick knotted, horizontal, bright yellow rhizome with slender roots be-



neath." "It grows in patches in rich open hilly woods." The stems grow rapidly in the warm days of early spring, soon reaching a height of six inches to one foot, flowering early, later yielding a berry which ripening, turns red in July, thus furnishing one of its many synonyms—ground raspberry.

The tincture is made from the fresh rhizome or horizontal root. The early settlers of America used *hydrastis* as a dye and also as a domestic remedy, both of which uses were learned from the Indians. Dr. Barton, of Philadelphia, in 1798, makes the first professional reference to the drug and gives credit to the Cherokee Indians as his authority. In 1828 Rafinesque, whom Hale designates "a scientific botanist, and a ripe scholar," gave considerable space to the drug in his *materia medica*. He states: "Internally it is used as a bitter tonic in tincture or infusion in disorders of the liver, stomach, etc." He also refers to its use in cancer among the Cherokee Indians. In 1833 the *Thomsonian Recorder* refers to its use in Thomsonian practice, and in 1833 Beach, the founder of Eclecticism, introduced the drug in his *materia medica*. Hale, of Chicago, claims the honor of being the first to call the attention of the homœopathic school to the virtues of our drug about the year 1855. The first systematic provings were made, so far as I can learn, in 1865 or '66 by a class of sixteen students of the Hahnemann Medical College, of Philadelphia, under the direction of Dr. Lippe, then professor of *materia medica*. Among the provers were our honored McGeorge, Dr. A. Korndoerfer, of Philadelphia, and Dr. M. M. Walker, now deceased, after a long and successful practice in Germantown, Pa.

Hale also speaks of excellent provings having been made by Drs. Burt and Nichols, of Chicago. The original provings and clinical experience alike show the limited sphere of *hydrastis* and also emphasize its exceeding value within that sphere.

If we follow the suggestion of Dr. Seibert in his excellent paper, the peg we would choose upon which to hang our knowledge of *hydrastis* would be the one symptom of catarrh, writ large, catarrh everywhere from oris to anus, including the eyes, ears, urethra and vagina. Among the provers two had dull frontal headache, two had nostrils stopped up, and four had constant coryza. Four provers developed aphthous sores in buccal cavity and three on lips. In two there was irritability of mucous membrane of pharynx and in two increased bron-

chial secretion. The manner of expressing the gastro-intestinal symptoms by the provers is interesting. I quote the exact language as recorded in the day books: "Empty, gone feeling at stomach," "Great sense of sinking and prostration at epigastrium," "Feeling of emptiness and dull feeling in stomach." The symptom of "burning in stomach" so valuable clinically does not appear in provings so far as I can discover. We have here our warrant for the use of *hydrastis* locally and internally in nasal and post nasal catarrh with discharge of thick white or yellow mucus, in stomatitis, in leucorrhœa with the thick, yellow, ropery discharge, and in the second stage of gonorrhœa, but with me the chief interest in the drug lies in its application to subacute and chronic gastro-intestinal disorders including the liver.

The picture to my mind is about as follows: Dull frontal headache, tongue coated white or yellow showing imprint of teeth, more or less tendency to stomatitis, empty, weak, faint feeling at pit of stomach and sometimes burning. Symptoms worse between meals, constipation, stools dry, mucous covered and with little inclination to stool. General debility and sallow complexion.

Close allies are *chel.*, *sul.* and *sepia* which must be differentiated.

*Hydrastis* may be the indicated remedy in gall-stone disease to overcome the constitutional tendency to these formations. Burnett, of London, in his usual dogmatic style placed *hydrastis* very near the head of the list.

From the earliest records *hydrastis* has been prescribed for cancer, especially of the stomach with differing views as to results. Bartlett, in *Clinical Medicine*, p. 366, says: "*Hydrastis*, which has really done considerable for this disease owes its efficiency to its control over the associated gastric catarrh." Price, of Baltimore, editor of "*A Pathogenetic Materia Medica*," is evidently of the same opinion. On the other hand, Lloyd Brothers, in "*Drugs and Medicines of North America*," 1885, states that "Several German homœopaths have reported cases of tumors of the stomach and pylorus which have disappeared under the careful and protracted use of *hydrastis*."

I would like to relate a recent experience. Mrs. B., age 66, consulted me Oct. 29, 1910, for epigastric pain following meals lasting one or two hours when relieved by vomiting. Vomited matter very sour and bitter. Patient sallow, cachectic, and

much emaciated. Examination revealed a hard mass in epigastrium which I regarded as malignant. In order to divide responsibility and satisfy the family I advised consultation with a prominent surgeon who confirmed my diagnosis and also advised against any operative interference. We also had the usual conference in regard to making the patient as comfortable as possible while she lived. After a few weeks' treatment I decided on hydrastis as the best indicated remedy which was given in the 2x dil. I also gave a few drops of mur. acid dil. in water after meals for an aid to digestion. She improved slowly but steadily. This treatment was kept up until last fall (about nine months) when she was so much improved that I advised its discontinuance unless symptoms should return. She has had no further treatment. In order to ascertain her present condition I called at her home last week and found her quite well. Her appetite and digestion are good, her bowels regular, has a good color and is steadily gaining in weight, having gained 11½ pounds. Upon examination, I declare upon my honor, I could not find the lump.

Our Eclectic friends must be close observers of the action of drugs, for when they use the single remedy, as they frequently do, their indications are nearly identical with our indications as founded on drug provings. Their use of hydrastis is no exception to this rule, as I could easily prove by quotations from numerous authors, did time and space permit. One quotation from Lloyd will prove my point: "Few agents have acquired a greater reputation in disorders of digestion than hydrastis. Hepatic torpor with constipation, and chronic gastritis are relieved by small doses of hydrastis. Among old school investigators along therapeutic lines, Sajous, of Philadelphia, probably stands at the head as to original scientific research. His special field of research being the internal secretions, or the function of the ductless glands in health and disease, and with him the therapeutic sphere of a drug is defined by its action on or through the thyroid, adrenals, pituitary body, etc. As a result of his study of hydrastis he states on p. 1386, Vol. 2, of "The Internal Secretions and the Principles of Medicine," as follows: "It stimulates the vaso-motor center and its action in therapeutic doses is limited to the stage of hyperæmia of all organs including the mucous membranes. It has been used advantageously, therefore, in various disorders of the latter,



namely, chronic gastro-intestinal catarrh, chronic rhinitis, otorrhœa, dysmenorrhœa, chronic vaginitis.

These similar conclusions arrived at by the three different schools of medicine working along independent lines would seem to define the sphere of hydrastis so accurately that in this instance at least we might be justified in claiming that medicine is not only an art but a science.

### ODDS AND ENDS: THERAPEUTIC AND DIAGNOSTIC.

BY

CLARENCE BARTLETT, M. D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of Germantown, June 16, 1912.)

I.—ASTHMA.—Our honored and efficient treasurer was a guest at one of the meetings of your entertainment committee. On this occasion he made a very interesting reference to a case of asthma which had been under his care for a number of years. The treatment of the case had not been satisfactory to him, although he had been able to please the patient by giving her relief when demanded. But now he had a different tale to tell, for by the use of lobelia hypodermically, the attacks had disappeared. As I listened to Dr. Gilbert's story, I felt impressed that the lobelia had done the work. Asthma is notoriously a disease of vagaries, and one is obliged to accept any reports of cures with reluctance. But in this case, we had a patient who had been under the same physician for years. The psychic and hygienic factors it would seem to me could be eliminated as the curative agencies. The profound impression the incident created upon me is the *raison d'être* for the present communication.

The difficulties and uncertainties in the treatment of asthmatic patients impels me to add my mite to the clinical study of the subject. The medicines which have given me the most satisfactory results are atropia and kali hydroiodicum, although some cases have been benefited or apparently cured by kali bichromicum, arsenic, nux vomica, and hygienic treatment.

Mr. —, æt 30 years, came under treatment March 18, 1912. He gave a history of asthmatic paroxysms during the

past four years, the past winter being the worst of all. The history of the case presented no special features other than the aggravation of attacks after heavy evening meals, and the remarkable liability to occur at 4 A. M. One cousin had had asthma for fourteen years. He had been through the usual routine of local treatment of the nose and throat, inhalation powders without number, and various proprietary and patent medicines. His prescription was atropia sulph., gr. 1-200 t.i.d. before meals, and potassium iodide, 5 grains well diluted, t.i.d. after meals. Up to the present time he has had no recurrence of seizures, but he still continues his medicines, the dosage of atropia, however, having been reduced to gr. 1-400 t.i.d. The very prompt recovery in this case suggests the possibility of the result being dependent upon psychic agencies. On the other hand, it may be urged that there was an abundant opportunity for psychic influences to work on the numerous previous occasions when he had consulted a new medical attendant.

The same line of treatment failed utterly in the case of —, aged 10 years. The boy weighed 125 pounds, and was decidedly emphysematous and bronchitic. His father is unquestionably syphilitic, but the son bears none of the stigmata of the disease. Adenoids were pronounced, and at my suggestion, were removed by Dr. H. S. Weaver, with only temporary relief to the asthma. His mother was inclined to coddle him, mainly in the direction of keeping him too warmly clad. Last summer his mother died, and lacking her care, the boy has been running wild, dressing as he pleased, and having a good time generally. A trained nurse on duty in the house informs me that he steals away at odd moments and smokes a pipe. The past winter was passed without an attack, and yet the winter before we were considering most seriously the advisability of having all subsequent cold seasons spent in the South. What cured, the absence of coddling, the use of tobacco or neither? The mother's sudden death at the age of 39, i. e., prior to the degenerative period of life, suggests that she may have had syphilitic disease of the heart, in which case, the boy should most certainly have been syphilitic. Potassium iodide failed to help him; still it was never given excepting in small doses.

Miss —, aet 28 years, consulted me October 16, 1906. She had asthma a number of years, and had been under the treatment of several eminent general medical men and rhinologists. Inhalation powders, electricity, internal medication, lo-

cal treatment of the nose and throat, proprietary specifics had failed utterly in bringing the desired relief. This case was very much benefited though not cured by atropia gr. 1-200 and strychnia sulph. gr. 1-30, three times daily. Improvement began at once and was maintained up to six months ago, when there was a relapse. Improvement was resumed on administering Fowler's solution in doses of five minims three times daily. This patient though of frail build, weighing less than 100 pounds exhibited a remarkable tolerance of atropia, which never caused either dryness of the mouth and throat or dilatation of the pupils. On the other hand, she gave a history of remarkable intolerance of potassium iodide, the smallest dose of which caused pustulation and coryza.

Miss ——— consulted me in June, 1895, at which time she was bedridden. Her illness was remarkable for the very free expectoration of large quantities of stringy mucus and the continuity of the dyspnœa. Kali bichromicum brought great improvement so that she was able finally to leave her bed. A change to potassium iodide in doses of five grains t.i.d. removed the balance of the dyspnœa so that she regarded herself as well. She has occasional paroxysms, and although past 70 years of age, is in what she considers for her, good health. She keeps the potassium iodide on hand, and finds it successful in throttling returns.

2.—THUJA IN PAPILLOMA.—Mr. ———, aet 78 years, had been suffering from a papilloma along the upper edge of the right ear. The irritation arising from lying on it had made it very painful and disturbed his sleep. Many local applications and mechanical devices had been employed for relief, but without any permanent result. Finally thuja tincture was prescribed locally, the applications to be made *ad libitum*. Improvement began in a week's time, and continued to a complete cure.

To my mind this minor ailment recovered as the result of the thuja tincture. Warts in this locality are very troublesome, and according to accepted teachings are removable only by the knife or the application of an escharotic. A pessimistic friend suggested that had I applied strong alcohol after the manner of using the thuja the result would have been the same. Thuja tincture is made with 88 per cent. alcohol, but the fresh plant contains sufficient moisture, so I am informed by Professor John Borneman, to reduce the alcoholic strength to between 60 per cent. and 65 per cent. This reduces the net alcoholic



strength to such a degree that it seems hardly possible that the alcohol *per se* could have been the curative agent.

3.—THE EARLY DIAGNOSIS OF PULMONARY TUBERCULOSIS.—The many essays bearing on the early diagnosis of pulmonary tuberculosis have been very interesting to me, as they doubtless are to most internists. While receiving benefit from their perusal, I must confess a disappointment respecting the lack of stress on the recognition of what might be called the "pre-physical sign stage of the disease." Any one who has the slightest knowledge of the morbid changes going on in a tuberculous lung, must admit, firstly, that there must be a period during which the changes are microscopic only; and, secondly, that in the beginning when the lesions are microscopic, they are still incapable of producing physical signs, or if capable of producing such signs, the latter may be present one day and absent the next. There also is lost sight of the law of probabilities. Tuberculosis is such a common disease that but few of us escape it in some degree. The probabilities are, therefore, always in favor of tuberculosis being present whenever there is a good reason for suspecting its existence.

A very large proportion of the cases which have not progressed to a stage of macroscopic lesions should be recognized by careful attention to the clinical history, and I say this without wishing to minimize the importance of physical examinations. I can make this remark more forceful by saying that the clinical history of most so-called obscure illnesses is of more diagnostic value than the physical signs.

Again, it must be borne in mind that in the earliest stages of tuberculosis repeated examinations are necessary to make a diagnosis positive. Should conditions be such at one examination only as to show but one abnormal sign, that one positive observation more than counterbalances the many times when the chest has been examined and pronounced healthy.

There are occasional cases,—personally I feel that I should say many cases,—in which a proper conception of the case can only be had after repeated observations. I have seen a few cases which I have been able to follow over a term of years. In the early stages, physical signs were absent. The patients made good clinical recoveries and considered themselves in good health, and yet in after years, the physical signs of a cicatrized and non-active lesion became very pronounced.

In all these discussions of the subject, there seems to be en-

tire neglect of the definition of an early case. From a practical standpoint, it should be understood as one in which cure is still a better than reasonable probability. The element of "time existence" is hardly to be considered in view of the many other important factors. We have all encountered cases which have gone from bad to worse in an incredibly short space of time, and physicians have been blamed,—for the most part unjustly—for their late grasping of the situation. It is these cases particularly that history is of paramount importance, for physical signs are only too often noteworthy for their entire absence, or for the difficulty of their recognition. Many years ago, we had in our college a student who gave a history of persistent evening rise of temperature. Repeated physical examinations by no less than five physicians reputed to be experts gave no positive information. The patient died of pulmonary tuberculosis during the vacation. But two days ago, one of my regular patients asked for an explanation of an evening cough and loss of weight, the symptoms being of but four weeks' duration. Physical signs were absent. But he lives with his mother-in-law who has been tuberculous for years. Does any one doubt that this is a case of pulmonary tuberculosis? The whole question of the early recognition of pulmonary tuberculosis rests upon a knowledge of the patient's temperament and constitution, his personal and family history, and the physical signs, utilized with good clinical sense.

4.—A GENERALIZATION IN DIAGNOSIS.—Many are the cases of chronic illness in which experienced diagnosticians have the greatest difficulty in giving a correct opinion. Analyzing these cases after the lapse of time has rendered their nature evident, we will find that nearly all of them can be classed under syphilis tuberculosis, interstitial nephritis, arterio-sclerosis, malignant disease, hysteria, or neurasthenia. In the light of knowledge given us by modern research, syphilis may be affirmed or denied beyond dispute by the Wassermann reaction. Still we must not forget that syphilitic individuals may have illnesses originating in other causes than their infection. Interstitial nephritis can scarcely escape recognition when once the physician's mind is directed toward it. Though the urinary findings be inconclusive, the high blood pressure and cardiac hypertrophy in conjunction with the remarkable train of functional disturbances which may accompany it, should settle the point. Concerning tuberculosis, I

have already spoken. Our greatest difficulties are found in cases of hysteria and neurasthenia. A good working rule respecting the diagnosis of these conditions is, to assume that when functional nervous disturbances are first manifested at or after middle life the burden of proof rests with the diagnostician; prior to the thirtieth year, the burden of proof rests with him who would contest the diagnosis.

In acute diseases of doubtful nature we have a different problem. A good working rule is that the majority of acute illnesses are of mild character and short duration. We know as a rule that a very large proportion of them recur in given individuals. Accordingly the advent of a symptom or symptoms which would mean but little or nothing to a strange physician tells the whole story of what is about to take place, to the family physician.

With certain notable exceptions acute diseases commence with symptoms of deranged function pointing unequivocally to involvement of certain viscera, e. g., lungs, stomach, throat, ear, etc. Physical examination at once tells the tale. Our main difficulties arise in respect of typhoid fever, diphtheria, acute tuberculosis, and acute and atypical infections in the course of chronic diseases.

So far as concerns typhoid fever, it is a safe rule of practice to assume its probability in all cases of fever persisting for more than three days without abatement and unattended by signs or symptoms pointing to a local affection. I know that the majority of such cases will turn out to be other than typhoid; but the treatment instituted in the expectation of an on-coming typhoid, can scarcely prove to be a mistake, for it can do no harm; while if carelessness is permitted, much harm and even death may ensue.

5.—THE DANGER OF PLACING IMPLICIT CONFIDENCE UPON CARDINAL SYMPTOMS ON THE ONE HAND, AND NEGLECTING THEM ON THE OTHER.—I can best point a moral by relating briefly the salient points of two cases: Mrs. —, aet. 46 years, had been operated by an eminent surgeon for carcinoma of the breast five years before consulting me (December 16, 1912). For twenty years she had had paroxysms of severe headache once or twice a year. For six or seven weeks past, headaches had been practically continuous; in fact she was never free from pain, although it varied in severity. She had a conical cornea which had existed for years. Her refraction had been



carefully worked out by an oculist well known for his painstaking work. She had double optic neuritis and the right knee jerk was greatly exaggerated. A diagnosis of tumor of the brain was suggested in view of the continuous headache, double optic neuritis, the history of former malignancy, and the exaggeration of the right knee jerk. And this diagnosis proved to be incorrect, for the patient "got well."

In another case, seen with a brother practitioner, the absence of an important symptom did not deter me from making an incorrect diagnosis, though no harm resulted from same. The patient was a painter, and had one attack of lead colic, since which time he had been scrupulously careful. Now he suffered once more, but this time there was no blue line along the gums, and the constipation was so obstinate that ordinary methods for obtaining a bowel movement were absolutely ineffectual. The diagnosis of lead poisoning was made against my better judgment for aside from abdominal cramps and constipation and the occupation of the patient there was nothing to sustain it. A suggestion of progressive intestinal obstruction was suggested and debated and cast aside. The youth of the patient was against malignancy. Yet the case turned out to be malignant disease of the colon.

6.—NEURALGIA AND QUININE.—Mr. —, aet 33 years, consulted me November 4, 1911. He had been suffering from supraorbital neuralgia for seventeen years. For many months the pains came on at nine o'clock in the morning and continued until three o'clock. Finally, they lost this periodicity, and the pains became continuous. All medication failed to give any relief. In 1905, a surgeon removed the supraorbital branch of the fifth pair. The pain remained away for six months when it returned as bad as ever. Following this he went through various therapeutic expedients at the hands of eminent medical men in New York, Baltimore and Philadelphia without results. While in my office the patient suffered greatly from the pain and begged for immediate relief.

Here was a case that presented the typical clinical picture of what we all recognize as "brow ague," and yet had gone unrelieved for over seventeen years. The operating surgeon belongs to a school noted for its great pathological and diagnostic technique. Physicians scarcely less eminent had failed with their medical treatments. Feeling that after all, the case may have been too plain a matter, and that each physician la-

bored under the impression that one of his predecessors had followed out the most rational plan of treatment, and had accordingly selected something unusual in the way of remedies, I prescribed quinine of five grains four times daily, and Fowler's solution in doses of five minims t.i.d. On November 11 the patient declared that he felt improved, and that this was the first time in the history of his illness he had felt that a remedy had cut short an attack. Relief became practical recovery in a month, but the quinine and arsenic were continued until early in February, when they were discontinued. I again saw the patient May 2, when he informed me that he had been free from his neuralgia.

This case teaches that one should never let the fact that a patient has been under the care of great men interfere with his judgment as to the proper medication. The line of men in charge included all shades of rational therapeutic beliefs to say nothing of osteopathy, Christian science, and other fads. Yet my respect for my predecessors led me to go so far as to speak to a surgeon about the case, and he suggested that I first make sure that the quinine treatment had been practiced properly by applying it myself.

About twenty years ago one of our very bright young physicians referred to me a case of bilateral sciatica, asking me to solve the problem "why." Such cases are in nearly every instance diabetic, and so it proved to be in this case. Sending my opinion to my colleague, he informed me that he had such a possibility strongly in mind, but that since Dr. ———, naming a man with overtowering reputation and learning—had examined the urine and reported it to be normal, he had felt some diffidence in view of his youth of investigating further in that direction. When one feels sure of his position he should follow his own clinical sense, though it runs counter in its teachings to the opinions of others of whom he thinks more than he does himself.

Quite recently there was admitted to the Hahnemann Hospital a case of old malarial fever. The most impressive point in the patient's history was that of a malarial attack at Panama which he stated was treated by overdosing with quinine, the attacks subsiding for the time being. Since his return to the United States, the paroxysms had recurred, and, up to the time of his admission, they had not been controlled. The patient was taken in charge by one of the assistant physicians, who

proceeded to treat him symptomatically. After ten days' time, no result having been attained, the blood was examined by Dr. Sappington, who reported malarial infection of the aestivo-autumnal type. In presenting his report to me, Dr. Sappington remarked that the condition of the patient was such as to make him a malarial carrier, and that the safety of the ward demanded prompt energetic treatment, and advised quinine in relatively small doses at short intervals; and that he considered the massive doses not indicated. Accordingly quinine was prescribed in doses of five grains every three hours. From that time on the febrile paroxysms ceased. One month later, when my service expired, the plasmodia were still in the blood. I do not know the final outcome of the case.\*

7.—A COMMON AND OVERLOOKED CAUSE OF BACKACHE AND SCIATICA.—In his book on "Differential Diagnosis," Cabot calls attention in a very forceful manner to the fact that by all odds the most frequent cause of backaches is sprain of the sacro-iliac synchondrosis. While aware of this before reading this fine work, its importance had not been impressed upon me so forcibly. My experience has borne out all of Cabot's teachings, and quite a number of recurrent and severe backaches have yielded at once to cross-strapping of the pelvis, once I fear to the disappointment of a patient who felt that internal medication should be the medium through which health should be restored.

8.—RECTAL INJECTIONS OF MUSK FOR OBSTINATE HICCUGHS.—What one of us has not seen obstinate hiccough causing great suffering in the terminal stages of peritonitis, uraemia, typhoid fever, and other acute and chronic affections. For the relief of such a condition, I know nothing that will surpass musk. It is preferably given by rectal injection in doses of 15 grains suspended in mucilage. The relief obtained by it usually continues for from six to ten hours. In some cases good results may be obtained by as small a dose as seven grains. The main objection to the remedy is its expense, which amounts to seven or eight dollars per dose; but I can assure you that the patient gets his money's worth.

9.—A NEGLECTED PRINCIPLE OF DIAGNOSIS.—A diagnosis which provides more than one pathological lesion for a com-

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\*On the day following the delivery of this address I learned that the patient's blood no longer contained the plasmodium and that he had entered the hospital service as elevator operator.



plete explanation is rarely correct. If multiple lesions are present and the diagnosis is correct, one will find as an almost invariable rule that one condition happens to be primary, and all the others are sequential. This rule has its exceptions, as shown by the following case: A middle-aged man was admitted to Hahnemann Hospital, suffering from diabetes with ulceration (septic) of one foot. He also exhibited marked rises of temperature, which were believed to be due to septic infection, the latter in turn being a complication of his diabetes. An examination of the blood was ordered, and malarial organisms discovered. Quinine at once put a stop to the febrile paroxysms, and the diabetes was treated dietetically. The surgeons who examined the ulcerated foot doubted that it was the cause of the fever, though admitting it to be a complication of the diabetic state. This is one of the very few instances in which I have seen two entirely unrelated pathological conditions co-existent.

The subject of this paper is one which can be prolonged indefinitely. As your rules permit but twenty minutes, and I have already transgressed upon your generosity. I will stop now.

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REPORT OF SKIN COMPLICATIONS OF GONORRHOEA.—By Past Assistant Surgeon W. S. Pugh, U. S. Navy. The literature upon the subject of the skin complications of gonorrhœa is so meagre that I take the liberty to report a few cases which came under my care in the service.

I have seen so many cases of this kind that I wonder that more has not been written on the subject. The idea of gonorrhœal skin complications appears to have originated with the French and we find it first appearing in the literature in the real attempt to describe it by M. Ladouzy, of the Paris Charity Hospital, in 1881, although suggestions relating to this had already been made ten years before by Seall, Villier, and Pédieux. Pédieux, in a memorable address before the Société des Hospitiaux Médical in 1872, stated, "Gonorrhœa is able to cause many and varied manifestations as ophthalmitis, rheumatism, skin eruptions, etc."

The symptoms produced in these cases give every evidence to show that there must always be a certain amount of bacteremia in these cases. This is certainly strikingly exemplified in the skin cases resembling a scarlet rash with typhoid symptoms and these cases are not rare, or at least so rare as most of us are inclined to think. The skin lesions of gonorrhœa can be divided into three groups: "A," diffuse scarletinaform or rubeli-form; "B," erythema multiforme; "C," purpura. There are perhaps others, but the above, I believe, cover those most commonly seen.

## EDITORIAL

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### THE STATE BOARD EXAMINATION.

THE first examination for medical licensure in the State of Pennsylvania under the control of the new Bureau of Medical Education and Licensure was held June 24th to 27th, 1912. A complete list of the questions presented to the applicants by the Bureau at this examination, will be found in the present issue of the *HAHNEMANNIAN MONTHLY*. A perusal of these questions will be found both interesting and profitable and will serve to convey some idea of the principles that are being followed out by the new Board in ascertaining the fitness or unfitness of applicants desiring to practice medicine in this state. It is evident at once that these questions are not easy in the ordinary sense of the term. We would feel quite sure that the applicant who could satisfactorily answer seventy-five per cent. of these questions would be perfectly competent to enter upon the practice of medicine. This deduction is strengthened by the fact that the questions are of such a nature that a mere parrot-like memorizing of quiz books would be of little help to the applicant in answering the questions propounded by the Board. They call for an exercise of the judgment as well as of the memory, and many of them present exactly the types of problems that physicians are called upon to solve in the actual practice of medicine.

The most common objection that has been raised against written examinations in the past has been the fact that they enable the examiners to gauge the ability of the student for memorizing facts but convey no idea of his ability to apply his knowledge to actual cases in medicine. We believe that the nature of the questions propounded by the Board will largely obviate this objection. Not only are the questions practical but they are blended in such a manner that a knowledge of the branch in which the student is being examined alone, will not enable him to give a satisfactory answer. Take, for example, question number two, under the heading of "Physiology, Pa-

thology, and Bacteriology": "In acute lobar pneumonia (croupous pneumonia) detail the local conditions, the determining cause of these conditions, and state briefly the effect on the normal functions of the lungs as well as on metabolism"? A correct answer to this question presupposes a knowledge of the bacteriology, the clinical course and the pathology of pneumonia, as well as a thorough acquaintance with the physiology of the lungs and of metabolism in general, and yet the question is by no means obscure or misleading and could be readily answered by any student who has been properly trained in modern medical work.

The questions dealing with "Homœopathic Materia Medica and Therapeutics" have naturally attracted our attention. We note that the new Bureau has largely abandoned the "symptom matching" type of questions and has presented questions in such a manner as to give the student an opportunity to show his general knowledge and familiarity with the subject. All of the questions presented in this branch are of an eminently practical nature and offer a very fair opportunity for judging the amount of practical information that the applicant possesses on this subject. There is but a small percentage of questions to which a categorical answer is demanded. Most of them permit a certain amount of latitude on the part of the various applicants.

There is every reason to believe that the new Bureau of Medical Education and Licensure has entered upon its work with the spirit of responsibility and of fairness that the profession has a right to demand of them. We believe that their first examination will meet with the unanimous approval of the physicians of Pennsylvania regardless of their school of practice.—G. H. W.

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#### TIME TO GET READY.

Now is the time for every homœopathic physician in Pennsylvania to begin to make his arrangements to attend the Annual Meeting of the State Society that will meet at the Delaware Water Gap, September 17, 18, 19, 1912.

Pennsylvania boasts of having the largest and most active homœopathic state medical society in the United States and it ought to be the pride of every homœopathic practitioner in the



State to aid in maintaining this enviable reputation of the Society by attending its meetings and bringing some of his professional brothers with him.

There is every reason why the meeting this year should be of more than usual interest. The president of the Society, Dr. Gilbert J. Palen, has been active in perfecting plans for the success of the meeting during the past three months and has initiated a number of new features which will add greatly to the interest and value of the meeting.

If you are a member of the Society you should be present for a number of reasons. First, because of the scientific and educational value of the meeting. All of the bureaus are in the hands of good men and many interesting and instructive papers are promised. There is probably no single opportunity open to the busy practitioner for obtaining a large amount of up-to-date information within a short period of time outside of the meetings of the State Society. Here he not only hears of the latest advances in medical science, but an opportunity is given for him to ask questions and to join in discussions bearing upon the subjects.

Second, there are matters relating to the policy of the homœopathic profession and of the legal rights of homœopathic physicians which will come up this year. Some of these are of extreme importance to the members of our school, and it is only proper and right that everyone should be familiar with them and should contribute his experience and his influence to the common good of our school.

Third, the social side of the meeting will be an unusually attractive one. The delightful scenery of Delaware Water Gap is well known to all. The hotel accommodations will be first class and the management of the Kittatinny House have assured the trustees of the Society that every arrangement will be made to take care of the meeting and of the members of the Society. There are numerous opportunities for automobile riding, tramps through the mountains, golf and other social amusements. The Philadelphia members of the profession will entertain the State Society at a smoker on Tuesday evening and at a banquet on Wednesday evening. You cannot afford to miss these occasions as we have been assured that on Tuesday night a startling innovation will be introduced.

There should be lots of enthusiasm at this meeting. Pennsylvania homœopathists should be justly proud of the mem-

bership of the Society, of its active and competent officers and of the efficient management of the whole organization. Why not make this year the banner year in the history of the State Society?—G. H. W.

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## BUREAU OF MEDICAL EDUCATION AND LICENSURE OF THE STATE OF PENNSYLVANIA.

A COMPLETE LIST OF THE QUESTIONS ASKED BY THE BUREAU AT THE EXAMINATION FOR MEDICAL LICENSURE HELD JUNE 24 TO 27, 1912.

*First Session.—Monday, June 24th, 2 P. M.—Physiology, Pathology, Bacteriology.*

1. Given an acute attack of peritonitis due to perforating appendicitis, state the pathological conditions that may be present, give the determining cause, together with a method of demonstrating this cause.

2. In acute lobar pneumonia (croupous pneumonia) detail the local conditions, the determining cause of these conditions and state briefly the effect on the normal function of the lungs as well as on metabolism.

3. Discuss briefly the lesions in the diffuse form of arterio-sclerosis both in the blood vessels and in important associated organs. Explain the effect on the function of these organs.

4. Describe two lesions of the liver that will cause lessening of the supply of bile and discuss in detail the effect of this loss.

5. Detail the lesions in typhoid fever, describe the determining cause and explain the sources of elimination.

6. Given a patient with an incipient tuberculosis of the lungs, explain the local lesions, describe at least two laboratory methods by which the diagnosis may be verified and discuss in detail each method.

7. Describe a method pursued in the preparation of diphtheria anti-toxin and give the reasons for the various steps.

8. Describe the lesions, name the causes and outline the technique of a method of demonstrating the variety of ophthalmia neonatorum.

9. In carcinoma of the female breast, name the varieties, describe the gross appearance of each and enumerate the avenues and usual points of metastasis.

10. Enumerate four of the usual pathological lesions capable of causing hæmaturia, describe two of these conditions (one of cystic, the other of renal origin) with a method of demonstrating each in life.

*Second Session.—Tuesday, June 25th, 9 A. M.—Symptomatology—Diagnosis—Toxicology—Medical Jurisprudence.*

1. State the local and the constitutional symptoms of follicular tonsillitis and differentiate it from diphtheria.

2. Enumerate the diagnostic symptoms of angina pectoris and name other diseases that resemble it, stating their points of difference.
3. Enumerate the symptoms and physical signs diagnostic of lobar pneumonia and differentiate it from sub-acute pleurisy with effusion.
4. Describe in detail the symptoms of scarlatina and differentiate this disease from measles.
5. Given a patient brought into the hospital unconscious, with a history of having fallen in the street, name four diseases which might exist and give the differential diagnosis.
6. State the diagnostic symptoms of acute miliary tuberculosis, name another disease with which it may be mistaken and differentiate the two diseases.
7. What is ptomaine poisoning? Enumerate the diagnostic symptoms of same, and state other conditions that may resemble it.
8. State the symptoms of acute anterior poliomyelitis in its different stages and differentiate it from neuritis.
9. Give the symptoms of acute (fatal) arsenical poisoning and enumerate a legal question which must be considered by the physician under these circumstances.
10. What medico legal reasons would justify a physician in terminating a pregnancy, state what steps should be taken prior to this action.

*Third Session.—Tuesday, June 25th, 2 P. M.—Obstetrics and Gynecology, Hygiene and Preventive Medicine.*

1. Name the common abnormalities of the breasts after confinement, their causes, prevention, local and hygienic treatment.
2. What methods would you adopt in order to relieve the vomiting of pregnancy, and on what theory would you use the various methods mentioned?
3. What symptoms would lead you to the apprehension of an oncoming attack of eclampsia before the convulsions set in? What is its treatment both before and after the convulsions?
4. What are the dangers of abortion (miscarriage); if abortion occurs, how are these dangers avoided and if they are not avoided how are they overcome?
5. What is the significance of excessive menstrual bleeding? What of inter-menstrual bleeding, and what of entire absence of bleeding?
6. Name the more usual bacteria which cause puerperal septicemia together with the methods of their introduction into the birth canal, the results of their presence there, and the prevention of these results.
7. Name four abdominal enlargements which might be mistaken for pregnancy and differentiate them from pregnancy.
8. Outline what are the essential conditions surrounding a safe and healthful supply of drinking water. If unsafe, how may the water be rendered safe for use?
9. During an epidemic of typhoid fever, what precautions are necessary, both as to the immediate family and as to the community at large?
10. In inspecting a house as to its plumbing, what are the essential points to establish?



*Fourth Session.—Wednesday, June 26th, 9 A. M.—Anatomy, Surgery.*

1. Enumerate the lesions to be considered resulting from severe blow upon the nose, and give the method of treatment of any two forms of injury selected.
2. Outline the essentials of a good amputation; describe any one major amputation, giving the surgical anatomy of the part selected.
3. Enumerate five of the more usual conditions capable of causing peritonitis; describe an operation that might be required for any one condition selected.
4. What conditions would warrant the enucleation of an eye? Describe an operation for the same.
5. In severe injury about the ankle joint, enumerate what possible lesions should be considered.
6. Describe the technique of intravenous infusion; state the veins accessible for infusion, and how to locate each.
7. What surgical conditions must be considered in retention of urine? Outline an operation for the correction of any one condition selected with reasons for selecting same.
8. State the usual position of the fragments in an oblique fracture of the lower third of the femur, and the muscular control of the fragments.
9. State possible lines of transmission of infection in palmar abscess, and give the external landmarks for the location of the palmar arches.
10. What symptoms and conditions referable to the gall bladder or liver would call for operative interference?

*Fifth Session.—Wednesday, June 26th, 2 P. M.—Materia Medica, Therapeutics.*

(Medical Society of the State of Pennsylvania.)

1. (a) What is ergot? (b) Give its official name. (c) Enumerate the official preparations. (d) Give dose of each. (e) What are its most pronounced physical actions?
2. Write a prescription, in the Metric System with the directions for administration, containing a nitrite and state what effect you would aim to produce. Another prescription containing an ammoniacal heart-stimulant and a third containing a hydragogue cathartic in pill form.
3. From what class of organic substances are acetanilidum and acetphenetidinum obtained? What is their general physiologic action? What is the action of most of this class of drugs upon the blood? Give the dose of the two above named. How are they excreted?
4. Give the official name of five salts or other preparations of mercury and state the therapeutic indications of each.
5. How would you treat a case of typhoid fever, together with the more important complications? Give dose and frequency of administration of each remedy you would use in this disease together with reasons for its employment.

*Fifth Session.—Wednesday, June 26th, 2 P. M.—Materia Medica, Therapeutics.*

(Homœopathic Medical Society of the State of Pennsylvania.)

1. Outline the application of *nux vomica* in conditions of the gastro-enteric tract; compare and contrast it with two other remedies applied in similar conditions.
2. Compare and contrast *Baptisa Tinctora*, *Phosphorus*, and *Arsenicum Album* in typhoid fever.
3. Outline the indications for the use of *Pulsatilla* in the genito-urinary organs of the female; compare and contrast it with *Actea Racemosa* and *Caulophyllum*.
4. Give the indications for the use of the following remedies in rheumatism: *Bryonia Alba*, *Rhus Toxicodendron*, and *Colchicum*.
5. Compare and contrast the applications of *Cactus Grandifloris*, *Aconite Napellus*, and *Digitalis Purpurea* in cardio-vascular affections.

*Fifth Session.—Wednesday, June 26th, 2 P. M. Eclectic Medical Society of Pennsylvania.—Materia Medica and Therapeutics.*

1. Give in detail the specific indications and doses of *Rhus Tox*, *Bryonia*, *Asclepias*, *Macrotys*, *Sticta* and *Sanguinaria*.
2. Name two sedatives, and enumerate the specific indications for each one, and their therapeutic uses.
3. What is a diuretic? Name five; detail the therapeutic use of each one.
4. What is strychnine? State its therapeutic uses, name four principal salts, and give dose of each one.
5. State how and from what quinine is obtained; enumerate uses and contra-indications; state the anti-periodic dose of quinine sulphate for a child one year old, and thereafter, according to age, until the adult dose is reached; and when administered.

*Fifth Session.—Wednesday, June 26th, 2 P. M.—Chemistry.*

1. What is the chemical reaction of blood? To what is it due? What is hemoglobin? Oxyhæmoglobin? Methæmoglobin?
2. Describe a quantitative test for urea in urine. What is the usual composition of biliary calculi? Describe their physical appearance. In what manner do they originate?
3. What is chlorin? How does it chiefly occur in nature? Describe its physical properties. In what form is it found as a component part of the human body? Mixed in equal proportions with hydrogen, what chemical action takes place?
4. Differentiate between human and cow's milk, as to percentage of water, proteid matter, sugar, fat and ash
5. Describe the technique of Fehling's test for sugar in urine. In case the test proves positive, what is the visible evidence thereof and upon what chemical basis does it rest?

*Second Year.—First Session.—Thursday, June 27th, 9 A. M.—Physiology, Chemistry.*

1. What is an enzyme? Name five and the specific action of each.
2. What changes take place in the blood during respiration?
3. State the origin of urea, and name the avenues by which it may be eliminated.
4. State the structural changes that occur in the uterus during menstruation.
5. Describe the process of dentition.
6. (a) What are carbohydrates? (b) How do they differ from hydrocarbons? (c) Name a carbohydrate capable of decomposition into alcohol and  $\text{CO}_2$ . (d) Give the common sources of methyl and of ethyl alcohol. (e) What is fusel oil?
7. What chemical reaction takes place when the following substances are added together in solution: (a) Sodium bicarbonate and hydrochloric acid? (b) Sodium chloride and silver nitrate? What chemicals do the following formulas represent: (c)  $\text{H}_2\text{SO}_4$ ? (d)  $\text{H}_2\text{SO}_3$ ? and (e)  $\text{H}_2\text{O}_2$ ?
8. (a) Describe two tests by which albumin may be recognized—in urine. (b) Upon what principle are they based? What is the specific gravity of healthy urine, and (d) upon what substance does urine mainly depend for its gravity over  $\text{H}_2\text{O}$ ? (e) Upon what substance does normal urine depend for its color?
9. Define (a) an atom; (b) a molecule. Define the terms (c) element and (d) compound. (e) What element is taken as the standard in atomic weight?
10. Describe the chemical changes that take place in milk standing in a warm place.

*Second Year.—Second Session.—Thursday, June 27th, 2 P. M.—Anatomy, Hygiene and Preventive Medicine.*

1. From heart to index finger and return, through what vessels would the blood current pass?
2. Outline the nerve transmission from the cerebral cortex to the great toe.
3. Describe the ethmoidal sinuses.
4. Give the anatomy of the inguinal region in the male.
5. Describe the muscular control of the shoulder joint.
6. What dangers may lurk about the kitchen and adjacent backyards of dwelling houses, and how are these guarded against?
7. What is the cause of malarial epidemics and how are they avoided?
8. Given a case of pulmonary tuberculosis, what hygienic regulations should control the sick room? What precautions will be necessary after the patient's removal, and how are these precautions carried out?
9. In the case of children in the school room, what precautions are called for as to their eyes and also as to their general health?
10. Describe the mode of conveyance of any three contagious diseases and explain the methods of prevention of such conveyance, as well as the methods of prevention of the spread of the disease after they have been contracted.



## GLEANINGS

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VACCINE THERAPY.—An editorial states that the value of bacterial vaccines in the treatment of infectious disease is now established, and that a working knowledge of their indications and methods of employment is a necessary part of modern therapeutics.

The extermination of an infection depends upon the ability of the body tissues to produce a sufficient quantity of anti-toxines. It frequently happens that the tissues are unequal to this task, then the injection of bacterial vaccines outside the immediate area of inflammation brings more tissues into activity in the production of anti-toxins, the latter being carried by the blood current to the seat of infection and recovery may be the result. Bacterial vaccines differ from serums in that they stimulate the production of antitoxines within the patient. If the patient cannot produce sufficient antitoxines they must be supplied by injecting serum.

Serums give the best results in acute general infections while bacterial vaccines are most effective in localized infections. While autogenous vaccines are theoretically the best, good results are often attainable with stock vaccines, especially in infections from gonococci and staphylococci.

Before beginning vaccine treatment it is best to determine the identity of the infecting germs, but this does not preclude the use of a well selected stock vaccine, thus boils, carbuncles and septic wounds can be successfully treated with a staphylococcus vaccine though the particular organism in the infection may not have been determined.

Reaction from vaccine administration shows that a proper vaccine has been selected and this is often a matter of diagnostic importance especially in obscure cases. The size and frequency of dosage are best determined by the degree of reaction, but the response from an initial dose cannot be determined in advance. If the reaction from the initial injection is profound the second injection should be a smaller one.

If there is no improvement after the initial dose, the subsequent doses should be increased until the inadequacy of bacterial therapy in this particular case has been determined. The interval between injections should be from three to five days though in acute conditions a shorter interval may be required. This mode of treatment is not unerring and may be regarded as auxiliary to other measures.

The method of bacterial therapy is revolutionary. It is as yet only in its infancy. It will be the privilege of the younger generation of physicians to watch its development and its progress and upon them will devolve the task in large measure of furnishing the clinical evidence that this system is the correct and rational one for the treatment of infectious diseases.—*American Medicine.*

QUINSY, TREATMENT OF.—As soon as pus is formed and easily located, the indication for incision in quinsy is clear. But up to this time the patient has already been suffering intensely, and is often in great danger owing to possible extension of the process to surrounding structures. If a way can be found to drain the pus accumulation at its inception by tracking the infection, both duration and danger will be lessened. Such a way the author has attempted to discover, and he has succeeded.

In its development the tonsil is nothing but an overgrown lymphoid deposit in the mucous membrane. The bottom of the fossa is formed of what in extrauterine life is called the capsule, which is separated by a small interval from the superior constrictor muscle. The lymphatics enter this space and drain into the deep cervical chain of lymphatics underneath the sternocleidomastoid muscle. It is also known that the crypts discharging into the supratonsillar fossa have poor drainage, and consequently are more subject to infection. By probing them in incipient cases one might relieve the tissues from pressure and thus stop further penetration of infection, or where pus formation has extended through the capsule, or a little beyond, probing might evacuate the small abscess.

With an ordinary tonsil slitter or tonsil probe the author probes these cases at their inception. In about 8 out of 10 cases this procedure actually can be carried out, with the result that after evacuating the few drops of pus the progress of the infection stops. With the aid of reflected light and a tongue depressor the tonsil is inspected, and the fossæ, especially the upper ones, entered one after the other. Where the bottom appears soft, the rounded point of the instrument is pushed deeper into the tissue, the capsule pierced, and the peritonsillar space entered. If pus has been reached, a few drops of it will follow the probe, and a sense of relief be experienced by the patient. The small opening made evidently suffices to allow gradual seeping out of the small amount of pus that may still be in the tissues.

The procedure is practically always successful where there are abscesses in the tonsil itself. If it does not succeed in other cases, one has not, at least, inflicted much pain nor any wound. It cannot take the place of incision in large abscesses, and will not do much good in multiple abscesses. It is practically painless and bloodless. This or any other method should be followed after recovery by removal of the tonsil.—M. P. Schuster, *Texas State Journal of Medicine*.

THE MOSQUITO.—The insect family, Culicidae, has been fully considered in Bulletin 21 of the State Department of Health, Commonwealth of Pennsylvania, March, 1911, but the following methods to prevent development in the various stages seem advisable to present in this Bulletin.

The campaign against mosquitoes should really be begun in winter, as at this time the hibernating species are found in houses. Thorough screening of the house with netting or wire screens having 18 to 20 meshes to the inch will keep mosquitoes from getting indoors. Should mosquitoes get in through openings of doors and windows, or through imperfect screening or absence of screens, their numbers can be reduced or even done away with, by the use of a paddle made of an oblong sheet of wire

gauze, tacked onto a strip of wood of suitable size to serve as a handle. In order to destroy them in the house, whether during winter or summer, the mixture of carbolic acid crystals and gum camphor, the use of which is detailed under the subject of the House Fly will be found effectual. In large cellars there should be several portions prepared at the same time in order to secure equal distribution of the vapor and equal effect throughout the cellar. The smoke from smouldering pyrethrum paralyzes the insect but does not kill and as they are difficult to find, this is but a palliative measure.

The burning of jimson weed (stramonium) and saltpetre is recommended. The space to be rid of mosquitoes must be tightly closed so that no fumes can escape for two hours. Three parts of powdered jimson weed mixed with one part of saltpetre is spread in a layer one-half inch thick on a tin sufficiently large to hold all the mixture necessary, or several tins may be employed. The powder is then lighted in several places and the fumes will shortly penetrate the space, provided at least eight ounces of the mixture is used for 1,000 cubic feet of air space.

The mosquitoes found on the ceilings of bed rooms in the evening may be quickly killed by means of a shallow tin cup or jelly-glass cover, nailed to the end of a stick and moistened inside with kerosene. This is placed under the mosquito which either falls into or flies against the oil and is killed.

Mosquitoes may be repelled by the burning of Chinese punk and by the less desirable application of equal parts of olive oil and oil of citronella to the face, hands and ankles every half hour or so. Carrying naphthaline or bar camphor in the pockets is also of some use in keeping mosquitoes off the person. In case one is bitten by mosquitoes the best antidiote is the application of a diluted solution of ammonia water to the wound as soon after the bite as possible. However, the most satisfactory means of fighting these insects are those directed to the destruction of the larvae and abatement of the breeding places.

Since the mosquito does not fly more than one-half mile from its breeding-place and, apparently only rarely as far as this, it is possible for any locality to free itself by bringing about a crusade against the mosquito within its own territory and for one-half mile around the same.

Many, and sometimes all, of the most extensive mosquito breeding areas in or around cities and towns or in a given locality are so situated that in the course of local improvement they will be done away with through grading or drainage. In the meantime such places are a menace to health and a positive nuisance; hence every effort should be made to have them drained or filled in, as the condition may demand, as soon as possible. Should filling in be necessary, much can be accomplished by securing in one way or another the co-operation of all parties who have ashes or dirt to dispose of and diverting this material to the mosquito breeding areas which are to be filled in. When the filling in is started the material should be delivered so that the edge of the pool will be the first portion to disappear under the material. Further material, should be added in such a way that the entire pool will be obliterated in the shortest possible time, which means that the material is to be spread out, first to a depth that will



leave no chance for pools to form. Until such permanent abolition can be secured, kerosene (one ounce to every fifteen square feet of surface) should be applied. In this proportion all larvae and pupae will be effectually destroyed, with the additional advantage of killing the females when they alight to deposit eggs. Usually, an application should be made once each month, though under certain conditions, its more frequent use may be advisable. It is more evenly distributed if placed in the water a short distance from the shore line. Barrels for rain water, if not screened and the outlet is at the bottom, may also be treated with kerosene. All standing water should be similarly cared for.

In order to more completely do away with mosquito breeding the cooperation of every householder must be invited and tenants must be directed either to remove all standing water or to screen it so completely with cheese cloth or some other material that this will effectively keep mosquitoes from getting at the standing water.—*Pennsylvania Health Bulletin*.

**THE COMMON FLY.**—The house fly (*Musca domestica*) has been fully considered in Bulletin 23 of the State Department of Health, Commonwealth of Pennsylvania, May, 1911. The following methods to prevent development in the various stages and for the destruction of the fly itself seem advisable to present in this Bulletin:

The breeding places should be eliminated. The larvae or maggots should be destroyed and the fly should be excluded from the home and food and all those not excluded should be destroyed.

Horse manure bears nearly the same relation to the house fly that stagnant water does to the mosquito. For this reason, it should be carefully collected in a common receptacle which should be carefully screened in order to prevent egg-laying. The same protection or destruction of all garbage, filth and decaying matter of any kind should be made.

Drains and alleyways should be kept clean and free from any of the materials in which flies breed. No privies or closets accessible to flies should be permitted or, if permitted, they should be screened. Fresh, unslacked lime or, if not obtainable, kerosene should be sprinkled freely in the privy vaults. The excreta from persons suffering from intestinal disease should be carefully disinfected immediately on discharge from the body.

All garbage slops and waste should be kept carefully and tightly covered until removed and destroyed and when taken away the container should be cleaned immediately after the removal of the contents. The ground contiguous to such containers should be treated with either unslacked lime or kerosene.

Cuspidors, especially those filled with sawdust, are very insanitary. All those permitted to be used should contain a 5 per cent. solution of carbolic acid, should be cleaned every day, using one of the following disinfecting solutions: Add one-half ounce of chlorinated lime (chloride of lime or bleaching powder) to one gallon of water; or three teaspoonsful of creolin, or eight teaspoonsful of a solution of formaldehyde (at least 27½ per cent. of gas, in solution) to one pint of water. The solution of formaldehyde is preferred.

The importance of dead or decaying wood or trees has always been overlooked. Flies frequently breed in the crevices; any of the last three named solutions may be sprayed (by using a pump spray atomizer) into such openings.

Flies should never be allowed to settle on food of any kind. All kinds of food stuffs exposed for sale are potent sources of danger as they are likely to be contaminated by flies which have walked or fed on sputum expectorated on the sidewalk.

Great care should be taken to have all houses screened before the fly time arrives, screening to be maintained carefully until winter time. Persons ill with infantile paralysis, typhoid fever, scarlet fever, diphtheria, measles and tuberculosis should occupy screened rooms and flies found in the sick room should be immediately destroyed and never allowed to escape. Houses within flying distance of a railroad should be especially well protected as flies contaminated with excreta from passing trains may gain access to the kitchen or dining room.

All milk, especially the baby's milk, baby's bottle and baby's bed should receive the same care and attention.

Among the various methods suggested for the destruction of flies, the following will give maximum results:

A piece of wire gauze, eight inches long and five inches wide, tacked to a wooden handle about fourteen inches long, makes an effective beater for striking and killing.

Pyrethrum powder heated in a pan or on hot coals so that it smoulders but does not burn, will give off a dense white smoke that paralyzes but is otherwise harmless; one ounce to every 1,000 cubic feet of air space should be used and the flies promptly swept up and destroyed. The best results are obtained if the room is darkened, leaving only a ray of light to enter at the window shade, as under these conditions flies usually accumulate on the ceiling where the maximum effect of the smoke is felt.

A solution made by adding two teaspoonfuls of formaldehyde to a pint of water sweetened with sugar and placed in saucers throughout the house will destroy many flies.

Another excellent solution is prepared by adding one dram (one teaspoonful) of bichromate of potassium to two ounces of water; or if a larger quantity is desired, 1 oz to 1 pint of water, which has been sweetened with sugar. This placed in shallow dishes throughout the house will not harm children should they get hold of it. It is a cheap solution and may be obtained at any drug store.

Cobalt chloride in the strength of 1 dram to 6 ounces of sweetened water is just as effectual, is non-poisonous, but is more expensive and much harder to obtain.

Another efficient method is by using a mixture of equal parts (by weight) of carbolic acid crystals and gum camphor. Liquify the carbolic acid crystals by gentle heat, break up the gum camphor into small pieces and pour the liquid acid slowly over the camphor. The acid will dissolve the camphor completely and the resulting liquid is permanent and only slightly volatile at ordinary temperatures. It volatilizes rapidly, however, in a shallow tin over the flame of an alcohol or other lamp and the vapor

is death to flies. Three ounces will suffice for one thousand cubic feet in a tightly closed room and it will require about half an hour to evaporate that amount. The vapor is not poisonous to man and is not destructive to materials or fabrics. It is not explosive but is inflammable and should be used with that fact in mind.

THINGS TO BE REMEMBERED FOR THE PREVENTION OF FLIES.

First: Flies can only breed in filth of the kinds mentioned and their presence is evidence that such material is at hand.

Second: They carry the cause of disease on their hairy bodies and legs.

Third: Keep them away from the sick, particularly those suffering with a communicable disease.

Fourth: Do not allow them to settle on the mouth, eyes, ears or nostrils of infants.

Fifth: Do not permit them to come in contact with food of any kind or to settle on the milk bottles of infants.

Sixth: Open privy wells or cesspools are particularly dangerous. Sanitary closets should be used.

Seventh: Uncovered or unscreened garbage cans and open drains should not be permitted.

Eighth: Physicians should see that the excreta of all patients with intestinal disease are disinfected and cared for in accordance with the regulations of this department.

Ninth: Manure should be collected twice a week and spread on the fields and composted or stored in fly-proof receptacles.—*Pennsylvania Health Bulletin*.

THE QUESTION OF INTESTINAL STASIS.—Although intestinal stasis is undoubtedly a condition of frequent occurrence, with definite symptoms and signs, its recognition escapes the attention of the average practitioner. A patient may suffer over a long period of time and be diagnosed as a dyspeptic or neurasthenic of a more or less incurable character, while the distressing condition might be entirely relieved, if its nature were understood and the proper treatment applied. The observing physician is very apt to recognize one of the secondary conditions and treat it, while the underlying cause itself is overlooked, since he pays especial attention to such signs as lassitude, poor circulation, nausea, loss of flesh and constipation. Jordan has recently published a lucid and convincing description of the condition and its causes, in which he clearly shows that the seat of the trouble is generally in the lower part of the ileum, the stasis being occasioned by a kink from peritoneal adhesions, very commonly as the result of an old appendicitis. He cites cases where the appendix has partially encircled the ileum, thus obstructing its caliber when the patient is in an upright position. As a result of this stasis bacteria ascend from the large intestine, invading the upper intestinal tract, entering the bile duct and producing cholecystitis and chronic pancreatitis, resulting in gallstones and its train of symptoms. Furthermore, the weight caused by this ileal stasis drags the lower coils of ileum into the pelvis and, by dragging on



its mesentery, pulls down the commencement of the jejunum and the last part of the duodenum, producing a kink at this point and subsequent obstruction. The resulting distension of the duodenum, with inflammation of its mucous membrane, renders it easily susceptible to pathogenic microbes with ensuing duodenal ulceration. The conditions leading to this duodenal distention, together with the ileal obstruction from a kink, are brought into play only in the upright position. Hence the explanation why these patients are comfortable while lying in bed and greatly distressed when on their feet.

This description of the cause of duodenal ulcer clearly shows that the operation of gastro-jejunostomy, while relieving the duodenum, will not cure the underlying cause of the difficulty. The important factor of the appendix in producing duodenal ulcer is recognized by Moynihan, who makes it a rule to remove this organ when operating for ulcer on the ground that the appendix is the source of the septic infection producing the ulcer. Jordan, however, emphasizes the fact that the appendix may not be the only seat of offense, since fibrous bands may otherwise assist in causing the disturbance. He lays great stress on the importance, in the matter of diagnosis, of the use of the fluorescent screen. After the bismuth meal he is able to clearly demonstrate the violent contractions of the stomach and duodenum in their efforts to force the meal beyond the seat of obstruction, the same being coincident with the patient's attacks of colic. By these X-ray examinations he has been able to prove the existence of stasis and its location, the same being confirmed by subsequent operation. These have been demonstrated so conclusively that he considers the subject beyond the experimental stage and that it is the business of radiographers to devote the necessary time and patience to adequate study of the duodenum.

THE OFFICE ANESTHETIC FOR SMALL SURGERY.—Arthur E. Guedel (*New York Medical Journal*, February, 24, 1912) says that the general anesthetic for small office surgery is often an annoying problem to the physician. The writer reports results obtained in small office surgery with nitrous oxide and definite quantities of atmospheric air administered by the patient himself. Two different anesthetic states are used—that of complete narcosis and that known as analgesia.

Complete narcosis. This method suffices well for very short operations and has to its credit many advantages over other anesthetics and even over nitrous oxide itself as administered by an attendant. The safety of the method is almost absolute, the action of the gas itself being a safeguard against accidents.

The patient simply holds the inhaler to his nose and breathes. When complete unconsciousness supervenes, the inhaler either falls or is removed by the concurrent anoxic muscular spasm, and recovery soon occurs. The available surgical anesthesia thus secured lasts usually from ten to twenty seconds, which allows ample time to complete various short operations.

Nausea and depression are extremely rare, even though a meal has just been taken. Patients as a rule have no fear of such an anesthetic as is

often so manifest when the inhaler is held by another, and indeed in return cases they often seem to anticipate pleasantly the exhilarant effect of the gas.

To secure this short complete narcosis, about ten per cent of air is admitted with the gas, which, as has been known for years, although it is less rapid in its action, gives a slightly longer available anesthesia than when pure gas is used.

Analgesia. This we know is an early stage in all general anesthesia, and consists of a pleasant sensation of numbness of the entire body, resembling closely alcoholic intoxication just short of narcosis. It is not peculiar to nitrous oxide alone, but occurs with any inhalation anesthetic. However, the difficulty of control of the vapor anesthetics render them useless for this purpose.

In this analgetic state, sensibility to pain is not entirely abolished, but is lowered to a surprising degree.

The patient holds the inhaler to his nose continuously throughout the operation, and breathes a mixture of about seventy-five per cent. nitrous oxide with twenty-five per cent. air, the depth and maintenance of this state depending entirely upon the quantity of air admitted. The percentage of air differs somewhat in various individuals. The patient is at all times in full possession of his faculties and able to follow the direction of the physician, unless complete narcosis is permitted by insufficient air supply. The state may be maintained indefinitely without any unpleasant results.

Dentists are recently making use of this analgesia, secured by the admixture of pure oxygen with nitrous oxide, for dental operations. However, the oxygen is expensive and inconvenient to handle and it is not necessary to the success of the method.

THE ANTISEPTIC AND GERMICIDAL PROPERTIES OF THE SILVER SALTS AND PREPARATIONS. The author has found by his experimental researches that preparations of silver albuminates are to be divided into two classes; first, those in which silver albuminates are present without free excess of silver nitrate; second, those in which an excess of silver nitrate is present. To the first class belong collargol and argyrol, good antiseptics, but poor germicides; to the second class belong protargol, ichthargau, albargin, and novargan, which are strong germicides, but have little or no advantage over the simple dilutions of the silver salts. The second class can be substituted clinically for dilute solutions of silver nitrate in ophthalmia neonatorum without loss of power or gain, the author is convinced, but collargol and argyrol cannot be substituted in the same way because the conditions call for an active germicide. He says with regard to literature: "Regard with the greatest suspicion antiseptic and germicidal values drawn on the gonococcus. This organism must live on human secretions—is too sensitive for such work, as it dies off in culture without apparent cause. Honest work is often rendered valueless, the error constantly recurring, as silver is allowed to come into reaction with common salt, resulting in the formation of silver chlorid, which is insoluble and has no antiseptic or germicidal power."—Dr. Marsh Pitzman, *American Journal of Ophthalmology*.

WILLIAM SPENCER, M. D.

THREE CASES OF GONORRHEAL IRITIS TREATED WITH ANTIGONOCOCCAL SERUM.—Three cases of gonorrheal iritis are reported, which were treated with antigonococcal serum. All cases have resisted the ordinary forms of treatment, such as atropin, hot fomentations, sodium salicylate, etc., had showed marked improvement after injection of the serum. In case 1, two injections of 2 cc. each of Parke-Davis & Company's antigonococcal serum was followed by rapid, complete recovery.

In case 2, the first two injections had a very pronounced effect upon the disease, but it did not appear to be lasting, for the left eye relapsed slightly and the right became inflamed. The last injection acted like a charm, the right pupil, which would not dilate, within twenty-four hours of injection became fully dilated and the iritis rapidly lost its acute character. The second injection caused slight symptoms of serum disease, urticaria and some irritation of the skin. In case 3, one injection was followed by a disappearance of symptoms. Antigonococcal serum being made from ram's blood, seems to be more likely to cause serum disease than the ordinary horse serum, and it is better to give both injections within a short interval and not to repeat the dose more than once.—Dr. T. Harrison Butler, *The Ophthalmoscope*.

WILLIAM SPENCER, M. D.

ACNE ROSACEA OF THE CORNEA AND ITS TREATMENT.—This condition produces pustules of the cornea which might be confused with phlyctenular keratitis but for the age of the patient, the appearance on the face, the recurrences for many years, and the deep scarring which results. Artz, Schirmer, Stephenson, Capauner and Erdman are cited, with their ideas and statistics. The palpebral conjunctiva shows nothing characteristic. The bulbar mucous membrane shows more or less congestion with episcleral nodes, which disappear completely after several weeks. These are gray in color and not transparent. Millet seed sized nodules appear in the subepithelial layer of the cornea, penetrating into the parenchyma, and the rest of the epithelium becomes chagreenated. They are absorbed but always have opacities accompanied by vascularization, and in certain cases have a reflex resembling cholestrin. Iritis is rare. Subjective symptoms are variable with neuralgic pains so intense that radium furnishes the only relief in some cases.

He has not tried holocain instillations, but had best results with dionin, followed in an hour by gentle massage with yellow oxid or scarlet red salve. Constitutional remedies are needed, as milk diet and alkaline waters. Radium applications for the pain, and iridectomy for optical reasons are necessary at times.—Dr. A. Darier, *La Clinique Ophthal*.

WILLIAM SPENCER, M. D.



## Monthly Retrospect

### OF HOMOEOPATHIC MATERIA MEDICA AND THERAPEUTICS

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CONDUCTED BY A. LEIGHT MONROE,

Miami, Florida.

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A PROVING OF RADIUM BROMIDE.—In the *North American Journal of Homœopathy*, for September and October, 1910, is published a proving of radium bromide by Dr. William H. Dieffenbach in collaboration with Dr. Royal S. Copeland, Dr. Walter Gray Crump, Dr. Henry C. Sayre, and Dr. Guy B. Stearns.

The proving was made from the purest obtainable radium bromide of an activity estimated at 1,800,000 to 2,000,000, the trituration being made by Mr. E. W. Runyon, of New York, in the presence of Professor Pegram, of Columbia University, who weighed out a definite quantity of the radium. The drug is preserved in leadfoil-covered glass bottles in order to keep the emanations and rays confined as much as possible.

The provers noted their daily symptoms for one week; family history was taken; physical examinations, including urinary and blood tests, were made, and after definite periods of taking the drug these examinations were repeated. All the provings were made in 30x, 12x, and 6x attenuations of triturated radium bromide of 1,800,000 to 2,000,000 activity. The person who made the triturations developed a number of symptoms (by inhalation presumably) and these were incorporated in the proving.

The 30x attenuation was first administered and while some provers developed many symptoms from this the majority did not, so that the 12x and later on the 6x were employed. The 6x produced very marked symptoms in several cases, so marked that a warning is given against employing it for therapeutic purposes.

All the provers, without exception, developed symptoms of muscle and joint pain with the modality worse on motion, the pain gradually wearing off. Most provers developed an air hunger; the symptoms were better in the open air. Except for the symptoms produced upon the eyes, the organs of special sense were not much influenced. Upon the respiratory tract the symptoms of cough were very marked (occurring late in the proving.) The alimentary tract presents a large number of symptoms; flatulence was marked, and alternating constipation and loose movements were produced. Two provers developed pain over McBurney's point. Upon the urinary tract increased elimination of solids, particularly of chlorides, is noted. Five provers developed albuminuria, and one of these had granular and hyalin casts. The female sexual organs showed delayed and irregular menstruation, with well-defined backache.

There follows a detailed list of all the symptoms experienced by the provers arranged in scheme form. This is too long for us to insert in full, but we give an abbreviation.

*General Symptoms.*—General lassitude for several days with periodical sharp pains in joints > by continual movement: > open air. W. H. D., 6x. Itching all over body at night. Miss W., 12x. Pains in all limbs, not better from moving about, but they wear off; recur on and off during the day, pains better from a hot bath. Miss W., 12x. Feeling tired and drowsy, > open air. M., 30x. Burning sensation and itching all over body. Miss H., 12x. All symptoms come and go, are better in open air or from walking. Miss H., 12x.

*Mind.*—Apprehensive, felt as if something was going to happen to her. Miss H., 12x. Felt depressed all day for no apparent reason; felt as if something was going to happen. Miss W., 6x. Bad dreams and restless all night; have felt low spirited all day; wish for things and have a great desire to be with people. Miss W., 6x. Irritable and easily vexed. M., 12x. Feeling of touchiness, easy to anger. F., 30x. Mind clouded and not able to think clearly or reason clearly; felt stupid, associated with dull frontal headache all day. F., 12x.

*Head.*—A succession of little pimples developed on forehead and chest; they were raised, red, and when punctured exuded serum, blood and a small amount of pus. E. W., 6x. Vertigo, dizzy feeling with pain in occiput; improved after sleep. Mrs. D., 6x. Vertigo lasted all morning > at 1 P. M.; markedly improved on going into the open air; also improved at noon-time after eating. W. H. D., 6x. Dull occipital headache; > pressure, > in open air. W. H. D., 6x. Vertigo with tendency to fall to left side, > in open air. W. H. D., 6x. Terrific pain in head over right eye, spreading back to occiput, lasting all morning. McD., 12x. Intense sharp headache commencing over left eye and spreading over the head, > from heat; > cold pressure. M., 12x. Sharp headache, over right eye, extending to vertex, > in open air. M., 12x. Dull ache in forehead all day with clouded mind; not able to think and reason clearly; felt stupid. F., 12x. Dull frontal headache all day; head felt light, somewhat relieved by squeezing, by pressure. Mrs. F., 30x. Sharp sticking pain in right side of head; in left temple. Mrs. F., 12x. Vertigo with dull pressure on vertex, also dull frontal headache. These symptoms wear off but return and are > walking and in open air. Miss H., 12x.

*Eyes and Orbit.*—Sharp pain in left eye; darting pain in left eyeball as if small bodies were moving in the eye. W. H. D., 6x. Swelling of tissues of left orbit with slight itching, > in open air. W. H. D., 6x. Eyes have sticky feeling and are reddened. Eyeballs slightly bloodshot. McD., 12x. When reading for a while the letters would dance and get blurred. McD., 12x. Eyes much congested. Quite a large amount of exudate from right eye forming yellow crusts. M., 12x. Margin of lids inflamed and burning. S., 6x. Eyes ache and head feels heavy all day till 4 P. M. Edges of lids slightly reddened and eyes sensitive to light, photophobia. F., 12x. Stinging sensation in both eyes, > in open air. Miss H., 12x.

*Ear.*—Tickling in ears very severe at night. Miss W., 6x. Sharp sticking pain just over right ear. Mrs. F., 30x.

*Nose.*—Itching and dryness of muc. memb. of both nasal cavities, > in

open air. W. H. D., 6x. Itching of nose. Miss H., 12x

*Face*—Formation of small papule in centre of left cheek; the same dried off and recurred a number of times. Heavy crust formed over the area where papule was scratched off; this again recurred several times. W. H. D., 6x. Severe aching pain at angle of right lower jaw. Mrs. F., 12x.

*Mouth—Tongue*.—Teeth painful and feel elongated. Miss H., 12x. Twitching and burning sensation in lips. (Ernesty.) Prickling sensation on end of tongue, like needles sticking in, lasted five hours. E., Metallic taste in mouth. W. H. D., 6x. Taste of drug metallic on swallowing; five minutes later feeling of warmth in stomach, as after taking whisky. S., 12x. Parched, dry sensation in roof of mouth, > from drinking small amounts of cold water, but parched and dry sensation returns. Miss H., 12x. Tongue bluish-white and thick—felt swollen. Speech seemed difficult and heavy. Miss H., 12x.

*Stomach*.—Warm sensation in œsophagus and stomach, noticeable half an hour after taking medicine. McD., 12x. Aversion for sweets, especially ice-cream, of which she is ordinarily fond. Mrs. D., 6x. Belching of quantities of gas during day. McD., 12x. Nausea relieved by eating. No appetite. M., 12x. Great hunger about an hour before meals, but takes very little to satisfy the same. M., 12x. Warm empty feeling in stomach, > after eating. S., 6x. Usual food is not relished, sour things taste good. Miss H., 12x.

*Abdomen*.—Slight colicky pains in abdomen and passage of foul flatus. McD., 12x. Colic and gripes in the abdomen, particularly about the navel, > after defæcation, > after passing gas. Much flatulence and belching of gas. Miss H., 12x. Cramping pain in abdomen while eating, > by pressure and defæcation; stools soft and yellow with very bad odor. M., 12x. Sharp, sudden pain at McBurney's point, also at location of sigmoid flexure above crest of ilium left side; these attacks occurred six or seven times during the week; the pains came quickly, like shocks, and passed off quickly. S., 6x. Two red maculæ,  $\frac{3}{4}$  inch in size, on right and left lower abdomen, slightly itching. F., 12x. Severe sacral pain with great flatulence, > after bowels emptied. Mrs. F., 30x. Colic in whole abdomen, > from heat, > from pressure, accompanied by internal chilliness. Miss H., 12x.

*Rectum and Stool*.—Passed large quantities of foul flatus. McD., 30x. Scanty, dry stool, little desire, rectum feels dry. F., 12x. After one dose 12x had six stools from 3 P. M. to 2 A. M.; the stools gushed from the rectum and were formed, they were malodorous and accompanied by foul, offensive flatus. Color yellow. Miss H., 12x. Have been obliged to use enemas on and off for years, and suffered from constipation. "Since making the proving my bowels move regularly every morning" (report of Miss W., one month after cessation of proving). Eight loose, partly formed stools, light brown in color; uncertain feeling about the navel; feels she must defæcate, but finds nothing but flatus. This symptom recurred several times. Miss H., 12x.

*Urinary Tract*.—Increased urination; urine has heavy sediment which sticks to vessel. Miss H., 12x. Dysuria during day; had to wait two minutes before urine came. 6x. Heavy cloudy urine during proving. Mrs. D., 6x. Urine radio-active by electroscopic test of provers S., McD., M.,



D., 12x and 6x. Faint traces of albumen produced in provers from taking drug. F., S., Miss W., McD., and Mrs. F. Urinalyses showed increase of chlorides in nearly all provers, and decrease of phosphates in the majority.

*Male Sexual Organs.*—Sexual desire lessened or absent for one month while taking drug. 6x. Three weeks after drug taking sexual desires stronger than usual. 6x. Extra emissions with dreams. 6x. A slight phimosis was aggravated; head of penis itched and burned. 12x. Slight pain in left spermatic cord when walking. 12x.

*Female Sexual Organs.*—Flow profuse and bright red with no headache and in good spirits (prover usually has severe headache and is depressed). 6x. Flow very slight first and second day, usually it is profuse for one month two or three days. 12x. Menstrual flow diminished on third, almost ceased on fourth day, stopped on fifth; usually it is profuse the first two or three days, and lasts five or six days. 12x. Leucorrhœa curdy and cheesy. 30x.

*Respiratory Organs.*—Tickling in larynx, < lying down, > in bed. Could not suppress cough when it had once started. > in open air. Pronounced tickling in supra-sternal fossa with cough. Mrs. D., 6x. Dry spasmodic cough, > smoking, < indoors, > eating, > out of doors. McD., 12x. Throat feels dry and raw, > swallowing and drinking cold water. M., 12x. Throat feels very raw. Expectoration of white froth, > open air. M., 12x.

*Chest.* Red rash between shoulder-blades, which itches. Miss W., 6x. Severe itching in left breast during day; at night a large red area in the centre of left breast, which is raised at that point and sore to pressure. Mrs. M., 6x. Red papules  $\frac{1}{2}$  inch in diameter on anterior surface near sternum both sides. S., 12x. Bruised sore feeling in thorax behind sternum. S., 6x. Beating pain at right of sternum, > at end of respiration. F., 12x. Heart—Blood-vessels—blood pressure. Tight constricting sensation about the heart, > in open air. W. H. D., 6x. Sharp pains in the region of the heart. M., 12x. Vertigo and palpitation of the heart during the afternoon. Mrs. F., 12x. In five provers the systolic blood-pressure was lowered by 10 to 20 cm. during the proving. Applied locally in massive doses, radium bromide produces endarteritis with supervening sclerosis and atheroma. Action on the blood: hæmoglobin percentage was increased in three, stationary in one, diminished in two. The red corpuscles were increased in four provers and diminished in two. Distinct leucocytosis occurred in two and leucopenia in one prover. In all provers, without exception, there was a marked increase of the polymorphonuclear neutrophiles of from 15 to 25 per cent., the small lymphocytes in all cases showing a diminution of from 10 to 30 per cent.

*Neck.*—Itching back of the neck and upper part of both arms. Miss W., 12x. Dull, throbbing sensation on right side of neck posteriorly. S., 6x. Pain and lameness of cervical vertebræ: < by dropping head forward, > by standing or sitting erect. F., 12x. Left sterno-cleido mastoid muscle feels lame. F., 12x. Red spot on left side of neck on arising; this disappeared and later a similar one appeared on right side of neck. Mr. F., 12x.

*Back.*—Severe lumbar and sacral backache all day; > after a hot bath. Mrs. D., 6x. Dull backache, lumbo-sacral region, > continued exercise. W. H. D., 6x. Pain like electric shocks in lumbo-sacral region, disappear

after continued exercise. W. H. D., 6x. Pain in back at sacral region which extended up the back to between the shoulders, > from exercise. M., 12x. At 4 P. M. a sharp knife-like pain for half a minute between third and fourth lumbar vertebræ, the joint sensitive to touch, the soreness remaining after the pain had ceased. F., 30x. On awakening, pain between sixth and seventh cervical vertebræ, > on motion. F., 12x. Lameness in muscles over left sacro-iliac synchondrosis. F., 12x. Triangular swelling with base upwards over sacrum, hot, > lying down with something hard pressing against it. Mrs. F., 30x. Backache between shoulders and lumbosacral region, > after walking. Miss H., 12x.

*Extremities.*—Sharp pains in joints of fingers, > prolonged exercise. W. H. D., 6x. Pain in right shoulder-joint, < motion, > heat. W. H. D., 6x. Lame sensation in right arm, forearm, and hand, > exercise, > warmth. W. H. D., 6x. Catch in left shoulder-joint, > on exercising. F., 30x. Severe crick under right shoulder; drawing, cramping pain in left elbow. Miss F., 12x. Pain and lameness of wrist while holding book. F., 12x. Sharp pains in left great toe, < motion, > exercise. Mrs. D., 6x. Numbness in both great toes, > after exercise. Mrs. D., 6x. Dull pain in right knee-joint, > motion, > continued exercise. W. H. D., 6x. Sharp darting pain in left calf, come and go suddenly. W. H. D., 6x. Shooting pains in joints, especially knees, ankles, and toes. Miss W., 12x. For the last three days corns and feet have been over-sensitive. McD., 12x. Dull pain in hip-joint at head of femur; much irritation. Pain under left patella. McD., 12x. Pain in popliteal space like a tired aching, > after exercise. M., 30x. Pains around the borders of the nails of the feet, < rest, > pressure and motion. M., 30x. Dull, aching, shifting pains in hip-joint and knee-joint, > exercise and cold. M., 12x. 11 P. M.: Sensation of needles pricking on the two middle toes of right foot with burning. S., 12x. Lameness of both groins after sitting and first beginning to move. F., 12x. Both thighs feel lame. F., 12x. Muscles in antero-exterior part of right leg lame, > walking and rubbing. Mrs. F., 12x.

*Skin.*—Succession of small pimples on forehead and chest; they were raised and red; when squeezed exuded serum, blood, and a little pus. Ew. Scaly eruption about size of 10-cent piece on anterior surface of right thigh, < scratching, > heat. W. H. D., 6x. Scaly circumscribed eruption on flexor surfaces of both forearms which bleed on being scratched; slight itching, < scratching, > dry heat, > in open air, > bathing in either hot or cold water. W. H. D., 6x. Itching all over the body at night. Miss W., 12x. Both hands of prover have been covered with evidences of chronic radio-dermatitis which had resisted treatment for several years. The lesions consisted of eczematous eruptions, cracks, and fissures, scaly excrescences, wart-like outcroppings and almost constant itching and burning. After the proving of radium these skin lesions gradually disappeared, and have at this writing (sixty days) not reappeared. W. H. D., 6x. Red rash between shoulder-blades which itches. Miss W., 6x. Corns and feet have been over sensitive. McD., 12x. Red papules  $\frac{1}{4}$  inch in diameter on anterior surface of chest near sternum, both sides. S., 12x. Several red spots on legs, thighs, chest, which itch and are < by scratching. F., 12x.

Action of radium bromide applied locally:—

(1) In mild doses. Dermatitis, with redness of skin, burning and itch-

ing: these symptoms gradually appear in from two to four days and gradually disappear in from two to four weeks, leaving a slightly pigmented area.

(2) A heavy or prolonged dose. The dermatitis is followed by blebs, exudation, swelling, and formation of scales and crusts, which may form and reform a number of times, and eventually there is tissue contraction with bleaching and the formation of a white, thin scar.

(3) An excessive dose. Necrosis of tissue will supervene on the dermatitis, simulating in many ways a rodent ulcer or epithelioma. This lesion will resist degeneration for many months, and when scar tissue formation has been secured a milk-white scar tissue area will result.

In many cases of overdosing, teleangectasis similar to nævi and birth-marks will be caused.

*Sleep—Dreams.*—Restless during night. Kept moving about in bed, which relieved the aching pain. Mrs. D., 6x. Irresistible sleepiness 4 to 5 P. M., > from sleep. W. H. D., 6x Slept soundly but had dreams about fires. Miss W., 12x. Dreams of committing suicide in some restless way. Miss W., 12x "Restless night on account of dreams which awakened and frightened me during the night; woke dazed and confused." Miss W., 6x. Awoke in morning feeling drowsy and weak: > after going into open air. M., 30x. After taking drug again had a night of many dreams. F., 12x.

*Fever and Chills.*—Felt hot all over body, so that she had to take off the bed covers. Mrs. D., 6x. Internal chilliness, followed by sensation of heat, as of fire of the skin; no perspiration (usually perspire freely), but my urine, which is usually scanty, is now profuse. Miss H., 12x. Internal chilliness associated with many movements of the bowels and flatulence. Miss H., 12x.

Effects of the local injection of radium gelatine into malignant tumors: From fifteen minutes to one hour after injection severe chill, followed by rapid action of heart and gradual rise of temperature, with large doses to 105 degrees F., with smaller doses to 102 degrees to 103 degrees F. This fever would remain in some cases for three days, in others from one to three weeks, in one case for six weeks. The higher and more prolonged the pyrexia the better was the resulting action on malignant tissue.

*SPIGELIA.*—By Thomas G. Stonham, M. D., Lond. *Spigelia*, or pink-root of Demerara, the *spigelia anthelmia*, has long been used by the negroes of the Antilles for the purpose of expelling round worms. And its allied variety, the *S. maratima*, has a place in the United States Pharmacopœia, and is used for the same purpose. This is the only use it has ever been put to in allopathic practice. Noticing the narcotic effects produced by over-doses, Hahnemann proved it and found it to possess "varied and great powers." He predicted that it was destined to accomplish results much more important than the destruction of worms, and his prophecy has been fulfilled in the homœopathic school.

Symptoms of overdosing for worms have been observed in children, and consist in flushing and dryness of the skin, often with some œdematous swelling of the face; delirium and sopor followed by dimness of sight or temporary blindness; there may be spasms of the facial muscles, especially of the eyelids, and subsultus tendinum. Pain, usually shooting or stabbing, occurs in many parts of the body, especially in head, face and chest, and predominantly on the left side.



# THE HAHNEMANNIAN MONTHLY.

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SEPTEMBER, 1912

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## BABY SAVING AND CHILD PROTECTION.

BY

WILLIAM W. VAN BAUN, M. D., PHILADELPHIA.

(The address of the Chairman of the Bureau of Pedology of the American Institute of Homoeopathy, delivered at Pittsburgh, Pa., June 21, 1912.)

DURING the past year the question of greatest interest in reference to infants and children has been based upon the world-wide and humanity-old conflict between human rights and property rights. The right of an infant to life, and the right of the child to a normal, healthy childhood.

The public has been roused as never before, to the appalling infant mortality and to the evil of child labor. Out of this has sprung two well defined national movements, complementary to each other—baby saving and child welfare. The public is learning with horror and amazement, that in all our large cities, in which we have taken so much pride, that of all who die during the year from one-quarter to one-third, are infants under two years of age, and of these babies who die, only one which is breast-fed dies to every seven fed in other ways.

They are learning that whereas every baby's birthright should be a healthy body, with vitality enough to carry it safely through the span of life, every fourth baby born in a large city dies before twelve months of life has passed by.

Out of every 100,000 births in our cities, 25,000 mothers are doomed to add to "the hopeful anguish of birth, the hopeless agony of death."

They are learning that the children of America have been denied an opportunity to enjoy their birthright of childhood, with its play, its proper physical development, its education and its training for citizenship.

They are learning that 65 per cent. of their school children vary from the standard of normal development, either mentally or physically, or both. That social and economic pressure is warping the minds and dwarfing the bodies of their children.

They are learning that, owing to the admission of ignorant aliens to this country, and to a neglect in organized society and a lack of essential laws and institutions, that there are now over six million illiterate people in this country; that one in seven of all the children in the United States between the ages of ten and fourteen are without schooling, and in eleven of the Southern States, that one in four of all the native white children of the "above age" limit are not in school at all.

The conscience of the public is being stirred,—stirred all too slowly, but the bitter cry of the children and bereaved motherhood no longer falls upon deaf ears and dulled hearts. The doctor and the social worker, the educator and the clergyman, the scientist and the law-maker, are moving in unison at last, as a relief force to overcome the lethal and degenerating influences of modern social conditions.

As physicians, what have we to offer to the public's startled inquiry: "What is killing our babies?" "Why are our children illiterate and degenerate?"

#### THE THINGS THAT KILL THE BABIES.

Hereditary and prenatal conditions. Improper midwifery. Improper nursing and feeding. Adulterated and poisoned food. Bad hygienic surroundings. Overcrowding. Bad air, especially vitiated room atmosphere. Filth—Flies. Ignorance—Poverty. Crime—Crime before and after birth: usually before.

These are the things that kill the babies. As physicians and as good citizens, we must show these things to the public and point out the remedy.

The solution of the baby-saving and child-labor problem goes down into the very roots of the economical conditions that produce social injustice, and reaches the basic principles

of preventive medicine and proper human development. The health and habits of the father and mother before and after marriage has much to do with infant mortality. The healthy baby demands a clean bill of health before marriage, by both parents, and the clergyman who refuses to marry a couple without such certificates is a good citizen.

The National, State and City Health Boards should compel the reporting of all cases of contagious diseases, especially those of sexual origin, and should supervise their treatment to the end. Drunkards, consumptives, partial idiots, degenerates, epileptics, syphilitics, and those with any form of venereal disease, should not be allowed to marry or procreate.

Hard labor, up to confinement interferes with the health or life of the fetus and newborn. The State should compel and provide for the mother, a reduction of working hours during pregnancy and a long rest after birth. Women should not be permitted to follow occupations which may lead to premature birth or miscarriage, such as working in lead, phosphorus, copper, mercury, nicotine, etc.

The man, and especially the woman, whose physical and mental organization is crushed under the weight of adverse moral, industrial and social conditions, is not fit to bring children into the world. Her offspring will surely show the effects of the wrong she has done and the injustice under which she suffers. It means *race degeneracy*.

The drift of farm and village population to congested cities under modern social, economic and industrial conditions, with the unhealthy environment of a very large proportion of the people of our urban communities, has already resulted in definite disease, and an alarming type of poor development and feebleness due to malnutrition. The natural moral and intellectual aspirations of a nation or race can never be realized unless a fine type of physical vigor is maintained.

Nature, under most adverse circumstances, makes heroic efforts to produce a physically perfect baby, and as a rule succeeds—a large number do not remain so very long. If the parents are diseased—are syphilitic, tubercular or alcohol-soaked, the baby product is not a success. It is estimated that 32 per cent. of all the babies who die before they are two years of age, are killed by ailments with which they were born. One-third of this 32 per cent. are victims of syphilis. Intestinal



troubles carry off 37 per cent., while contagious disease kills less than 5 per cent.

A breast-fed baby is immune to contagious diseases, but not the bottle-baby.

#### IMPROPER MIDWIFERY.

There are probably a million births a year in the United States, and there is not a sufficient number of trained physicians able or willing to take care of these cases. Jacoby states that "one-half of our babies in all countries are born under the supervision of midwives." We, as a nation, have done nothing to educate these women, so it is no wonder that many babies and mothers are lost for want of proper care. It is our duty to advocate schools of midwifery and admit women under common sense entrance requirements, and teach them the proper care of the pregnant woman, the conduct of normal labor, the care of the mother and of the baby immediately after birth, the simple principles of artificial feeding, if necessary. The diagnosis of abnormalities, so that she will recognize the difficulty and send in time for the trained physician. Examination and license under State Board supervision should go along with these provisions.

#### BREAST-FEEDING.

One breast-fed baby dies to seven fed on artificial food. The real figures for the mortality of babies below one year has been found to be as follows: Exclusively breast-fed, 6.98; mixture of breast-milk and artificial food, 9.87; artificial food alone, 19.75.

Every mother can nurse her baby if she wants to. This is good, sound doctrine. It is sane, helpful and optimistic. All the same, some women cannot do so. They are very few. We are all well versed in what is necessary for the woman to do to develop her breast while carrying her child. We know what must be done to properly control the quantity and quality of her milk, and it is our duty to insist that the woman must nurse her child, when from social or other silly reasons, she refuses to do her maternal duty.

But what about the willing mother, with a good milk supply, who, sinking under the grind and stress of poverty, must

abandon her baby or starve? Starving woman soon makes no milk.

A booklet published by the Philadelphia Baby-Saving Show last month supplies much information to the mother. In the matter of housing and its effect on the baby, the booklet says: "Are the wall paper and plaster dry and clean? Is there plenty of sunlight in the rooms? Are there any pools of dirty water, dump heaps, manure heaps or anything else that causes a bad smell near the house?"

Under the head, "Care of the Mother Before the Baby is Born," the booklet says: "In the first place, she should not work as hard as usual."

Under the various headings for care of the baby is found such advice as this: "From feeding time to feeding time keep the baby quiet. He should sleep alone. It is very bad for him to be in the bed with older people.

"Your baby needs fresh air all the time. Outdoor air is the best. In fair, warm weather he may be kept out of doors most of the day, and in hot weather most of the day and night, in open places, in the shade, parks, squares or near the water. Keep the baby out of the kitchen. Don't consult a neighbor when the baby is sick. Get a doctor."—*The North American*.

This is good advice for the mother, who through ignorance of these things, might let her baby die. But it calls for a price and often, too often, she has not the price. It means nothing but added misery and sorrow to the mother, crushed under industrial conditions, whose poverty forces her to deny her baby all these things. She must turn her baby over to the questionable care of a neighbor in similar distress, or she must entrust it to the services of a Day Nursery or Milk Society, while she toils and sweats all day long, in order to feed her hungry, destitute brood. Poverty is the cause of the dirt, the flies, the vitiated room atmosphere and the bad living conditions that kills the babies; and ignorance is the hand-maiden of poverty.

If our well-known philanthropists, who having robbed and plundered the public of a vast amount of wealth, and who are still continuing their active spoliation of the submerged nine-tenths of our population, would stop for a while their commendable work of buying pictures, and building laboratories, hospitals and libraries, and turn the current of their munificence to a well-organized trust for bettering the housing and

living conditions of the extreme poor, they would be more useful citizens than they are now, and they would lay up for themselves "Treasure in Heaven, where neither moth nor rust doth corrupt, nor thieves break through and steal."

They would miss the applause of listening Senates, but they might enjoy their predatory wealth.

#### FOOD POISONERS AND DRUG DOPERS.

The sympathetic consideration of our National Government for property rights, as shown to Food-poisoners and Drug-dopers, and its heartless disregard of human rights in their refusal to protect our infants, children and people, is effectively pointed out by the *Journal of Commerce* in quoting opinions in reference to the Referee Board and Saccharin and other poisons. Secretary Wilson said: "I want you to understand that the Referee Board was organized and put into action to conserve the interest of the manufacturers. You need not fear anything from the Referee Board," and Secretary Nagel stated, "When the question about these foods is a close one, every consideration should be shown the man who has invested his money in a business."

In a question between money and health, the decision was to give the adulterators and the dopers ample time to unload their poisoned products upon an innocent and ignorant public. Because of its sweetness, the food-dopers early seized saccharin to cheat the public who buy prepared foods. A very small amount sweetens a large quantity of prepared fruits or vegetables or bottled drinks. Sugar is a necessary food, especially for children. Saccharin has absolutely no food value, when taken into the human system it acts as a foreign body, and is entirely eliminated by the kidneys. When it is introduced into food or drink as a substitute for sugar it is a fraud and cheat.

The drug-dopers with their soothing syrups, their tonics, their bitters and other combinations, cause a large infant and child mortality, and they pave the way for degeneracy in the children who survive their use.

#### CHILD LABOR—ITS CAUSE.

The chief cause of child labor is family necessity,—poverty. Abolish the danger of starvation, and child labor will not have



to eke out the earnings of the father or widowed mother. Man's greed of profit makes him pitilessly, murderously negligent of his fellows' welfare. 'The greed of the wealthy, the selfishness of corporations and all employers who rob the poor and defenseless, with cruelly inadequate wages, who deny their employes a wage sufficient to furnish themselves and families with the bare necessities of life; who take no steps to relieve the family of the father who has been killed or crippled in an industrial accident, or has been incapacitated by some disease, many times the result of industrial conditions; these people are responsible for the forcing of children into mines, factories and sweatshops.

These dividend-seekers on watered securities are responsible for the economic distress, for the social unrest, for the baby mortality, for the evils of child-labor, for the increased cost of living. They are responsible and they should be compelled to advance the wages of human labor in keeping with the prices of life's necessities. The advance in wages should be equal and coincident with the advance in the price of commodities, and not lag behind, otherwise the result is economical and social distress.

According to the latest census report, factory workers in the United States were paid an average of \$519 for the year, an increase of not quite nine per cent. in five years, but the average cost of living had increased more than 40 per cent. during the same time.

Corporations are said to have no souls but surely there is a way to awaken the consciences of the men who govern the corporations. Righteousness and justice must prevail. The State must wrench from the few their power to prey upon the many and fatten off the hunger-driven millions. A high type of citizenship demands a protected childhood. Of the 65 per cent. of children below the average standard, mentally, morally and physically, a vastly disproportionate share comes from our "tenements." Why do these children not have a chance in life? Why do they not have enough to eat? Why do they not have a place to play? Why are they not properly educated? Why are they not protected from vicious environment and brutal companions, during these tender, formative years of mind and body. Good citizenship demands a change. Few of the children whose infancy and youth are spent in factory, sweat-

shop, mill and mine ever become normal men and women. Many are irretrievably ruined for life.

We must awaken an intelligent public interest. The future of the race depends upon its women and children; with their deterioration, national decadence is at hand. Our children must not be stunted in soul and body, to enlarge dividends. They must be made healthy, self-reliant human individuals, able to take care of themselves. Children stunted in body, mind and morals are a social and political loss to the extent that their future efficiency as citizens is reduced. Anything that will release the child from the slavery of the mine, factory or unsuitable occupation, will raise the economic standard. Show the working people that child-labor cheapens adult labor and aggravates the problem and they will assist you with stoic perseverance. Awaken the public conscience to a realization of the fact that the child is a national asset and heedless America will protect her children.

To our lasting disgrace, Philadelphia and Pennsylvania leads the nation and the world in the number of child laborers. Pennsylvania has 44,312 children under 16 years of age employed in industries. More than twice as many as are employed in New York State. Pennsylvania's child workers are 3.3 per cent. of the whole number employed, while New York's are but 1.7 per cent.

"New York with nearly 5,000,000 population employs in factories and mercantile establishments 10,111 children under 16 years of age. Philadelphia with less than 2,000,000 employs 12,539 children of the same classification. This is 50 per cent. more than are employed in the whole State of Illinois, with its great city of Chicago, and 33 1-3 per cent. more than the entire State of Ohio, whose metropolitan districts include Cincinnati and Cleveland."

Are we to sit idly by while our mills, factories, mines and sweatshops consume our children? Every child robbed of its infancy and childhood deteriorates or dies and the standard of efficiency of our Nation is lowered, with an ever increasing number of invalids, paupers and criminals, with their cost of public maintenance. We must fight to protect every human right from unjust infringement by property greed. Social and economic justice demands that the continuance of child labor in America must stop.

## CAUSES RETARDING THE SPREAD OF HOMŒOPATHY.

BY

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It has long been a cause of wonder and regret to well-informed and thoughtful physicians of our school, as well as the laity, that homœopathy, "the Science of Therapeutics," did not spread as rapidly as its merits deserved. It has been a matter of wonder, especially, that the more conscientious and liberal members of the old school have not more generally recognized and acknowledged the superiority of the method in saving life and conserving the health of the community. For surely all that should be needed to convince them would be conscientious investigation and fair trial. And Hahnemann says that "for a physician to leave untried anything that pertains to the cure of the sick is a crime."

That homœopathy is a science under law is well known to all real students of the subject, and is easy of demonstration to all others who will listen and are open to conviction.

Like other inductive natural sciences, it possesses the necessary two series of independent phenomena connected by the formula of their general relation—symptoms of the sick—therapeutic law—symptoms of the drug.

It possesses also the two essentials of such a science:

First: The capability of infinite progress in each of its elements, without such progress involving the destruction or denial of what has been previously constructed or received.

Second: It furnishes means of prevision; it provides for the prediction of future events within its own domain.

The astronomer, for instance, by means of the science under his law, predicts the hour of appearance of a comet which returns but once in many years, and locates new stars, as in the discovery of the planet Neptune.

The science of therapeutics, to be such, must be able to do likewise; that is to say, given certain phenomena (symptoms of the drug) it must be able to predict certain results with respect to certain other phenomena (symptoms of the sick) from the action of drugs administered under its direction. This it does.

Hahnemann himself furnished the most notable example of this prevision in connection with the first epidemic of Asiatic



cholera in Europe in 1831-'34. Before the dread disease had reached Germany, and while yet neither he nor any of his colleagues had seen a single case, he predicted that certain remedies, at certain stages, would be indicated and curative.

Dudgeon, in his lectures on homœopathy, says :

"Hahnemann, guided by the unerring therapeutic rule he had discovered, at once fixed upon the remedies which should prove specific for it, and caused directions to be printed and distributed over the country by thousands; so that on its actual invasion the homœopaths, and those who had received Hahnemann's directions, were fully prepared for its treatment and prophylaxis; and thus there is no doubt many lives were saved and many victims rescued from the pestilence. On all sides statements were published testifying to the immense comparative success that had attended the employment of the means recommended by Hahnemann before he had seen or treated a single case. This one fact speaks more for homœopathy, and the truth of the law of nature, on which the system is founded, than almost any other I could offer, viz., that Hahnemann, from merely reading a description of one of the most appallingly rapid and fatal diseases, could confidently and dogmatically say such and such a medicine will do good in this stage of the disease; such and such other medicines in that, and that the united testimony of hundreds of practitioners in all parts of Europe should bear practical testimony to the accuracy of Hahnemann's conclusions."

The well-known "Chapman case" is a good illustration of the fact that the science of therapeutics is truly a science. In this instance identical letters were sent to ten representative physicians of each school in as many of the large cities of the United States requesting a prescription for an ailment characterized by certain described symptoms, and asking that the name of the remedy be given with each prescription as the applicant was a medical student.

The result was that all of the ten homœopaths prescribed the same remedy—*lycopodium*—and each of the ten allopaths prescribed different remedies, and two of them prescribed proprietary drugs.

It would be difficult to conceive of a more striking contrast between the results of scientific accuracy and blind guess work. It is at least improbable that ten physicians, in as many widely separated cities, and all unaware that the others were connected

with the case, could have "guessed" the same conclusion. The only fair inference is that a scientific rule guided them to the unanimous conclusion; moreover, a similar test can be applied at any time with the same result.

Homœopathy, then, being demonstrated to be a science, and bearing such direct and intimate relationship to the paramount subject of the public health, the importance of the question is emphasized: Why does homœopathy not spread and become generally accepted with the rapidity its merits warrant us to confidently expect?

On being notified by the chairman of this bureau that this subject had been assigned me, I conceived the idea, happy to me (if not to them), of having a number of prominent and representative physicians do the best of the work for me, and in pursuance thereof, I put the idea into practice by writing to each, asking for his answer to the question. The replies were generous in number, instructive in matter and useful to the writer. I already had positive views on the subject, and was pleased to have them confirmed by such authority, and I now voice the hope that these kind collaborators of mine may elaborate upon their concise replies to my queries here before you.

With their permission I will quote freely from their various replies:

Our genial, white-haired friend, from Washington, grand-nephew of his country, whom we all love for his sunny nature, expresses himself in his usual clear and convincing style, as follows:

"Any science or art representing the results and beneficence, such as is offered by homœopathy, should go because of its own merits. That most of our colleges have not the students they should have; that they do not graduate sufficient students to supply homœopathic physicians, is a fact. But the causes are within the school. The real and good homœopathic physicians are fast becoming intolerant of the weakness of those who, because of their commercial spirit, or for other reasons, do nothing. They have themselves become indifferent and are not insisting upon the patronage of our colleges by the possible students of medicine. This indifference to the growth of homœopathy is more marked in the attitude of those who simply use their alliance with the Institute and homœopathic societies to gain business, and practice entirely after the easy method offered by the compound tablet of all pharmacies and com-

panies, who offer remedies and scientific (?) treatment for all diseases. I am taking this position in part because of having been present at an interview of two representative men of two of our colleges. They both admitted that not twenty-five of their students matriculated because of their desire to become homœopathic physicians, and that they had not graduated more than four or five real homœopathic physicians out of their classes averaging between thirty and forty. This statement seems appalling. I will not take your time to offer the explanation, but to summarize causes, I will say that selfishness, lack of a sense of responsibility to propagate the truth which has given the men who are our representatives their position, and lack of proper propagandistic work on the part of those who should be thankful that the truth has been given them and that they have been endowed with minds to receive the same."

Dr. W. A. Dewey, of Ann Arbor, an editor of some note, of whom I have no doubt many of you have heard, replied at some length, but he writes so well I quote him freely. He says:

"1. Prosperity. Throughout the country are men who have grown rich and fat through its benefits. They have made a success in its practice. They overwork themselves and later do not introduce a successor for fear they may cut off some of their income, nor do they look about for a student. I can perhaps name fifty who have retired well to do, and left no one in their place. They never did anything for homœopathy, never had time. They will not even support a periodical, saying they have no time to read one. Some of these die and their clienteles pass into allopathic hands. They never attend societies for fear some of their practice will get away. Seven hundred of the 1,400 homœopathic physicians of the state of New York do not belong to Institute, state, or local homœopathic society, have no society affiliations at all. They are unknown except in their own cross roads where they have generally the best practices.

"2. Slovenly Homœopathy. These practice to get and keep patients, give any old thing to relieve, and so their practice degenerates into what is worse than allopathy, and yet they trade on the name of homœopathy for revenue only. The difference is soon discovered and so the cause loses ground.

"3. Lack of Co-operation. Indifference. Jealousies. You see this in every city and in every town where there is more than one homœopath. In every college, and here it works



harm, one teacher's teaching is demolished by another teacher, the student develops scepticism and becomes anything but an enthusiast in the cause. We see something of this state of affairs in the fact that one college will sometimes refuse to adopt a text-book on a subject written by a teacher in another college. Lack of harmonious and concerted action. There are those who knock at every opportunity; the Institute was once split by the knockers.

"4. Lack of Organization. Organization is impossible under the present conditions. There are of course spurts of it, but they are worse than nothing for the reaction finds us worse off. Business methods are ignored. Legislative committees are especially inactive, there is a lack of aggressiveness everywhere. For instance, I know of one examining board, a mixed board, where a homœopath was appointed in place of one whose term expired and where it was promised that there would be fair play for our graduates which did not obtain under the former conditions. The new appointee, no sooner had taken his seat when his head swelled with such importance that the old school members could by a mere tap on the back make it distinctly visible, and of course they had no trouble in controlling him.

"5. Toadying to the Old School. I know a surgeon in Chicago, a fine one too, who would rather have Senn (when he was alive) pat him on the back and say he was the stuff than to receive all the praise the homœopathic profession could bestow upon him. It would mean more to him. To me this would be but insulting patronage.

"6. The Text-book Question. We will never prosper and depend on the allopathic school for our text-books in surgery, obstetrics, practice (and some of ours are worse than theirs), eye and ear, etc. We have the men, we should have books."

Dr. William H. Vanden Burg, with whose writings you are all familiar, writes as follows:

"I would give as a first cause, the great changes that have taken place in the education and practice of the regular school, they having practically discontinued the use of drugs and devoted their entire attention to diagnosis, surgery, and hygienic, climatic and dietetic treatment.

"Second, the development of the science of bacteriology which has thrown so much light upon the infections and brought about the present discussion of serum and vaccine therapy.

"Third, the aggressiveness of the osteopathic school which

has attracted to its ranks many of the better class of students who formerly studied homœopathy, they seeing in this newer system a quicker method of making a livelihood.

"Fourth, the spread of the doctrine of Christian Science with its emphasis on the benefits of suggestive therapy, this cult having appealed to most of the followers of the former high-potency homœopaths by demonstrating to the laity that the large majority of the cures in medicine, outside the infectious and surgical diseases, are due purely to suggestion.

"Fifth, there is a great disinclination on the part of the better educated students about to enter medicine to take degrees from institutions bearing sectarian names, most students wishing to be unhampered and at liberty to follow the dictates of science wherever they may lead."

When, in the beginning, I said, "I had written to representative men" of our school, I had in mind that "men" embraced "women," and Dr. Sarah M. Hobson replied:

"The progress in preventive medicine which diminishes in large measure the need of internal medication:

"Conservative surgery which operates to the same end.

"Indolence: It is easier to give codeine, morphine, coal tar derivatives and such like palliatives, than to regulate the living, search for causes and patiently remove the results.

"The number of practitioners homœopathic only by accident, and without either conviction or practice, who on account of environment find it profitable to trade on the word 'homœopathic' for the sake of surgical or other reference work.

"The inability to earn a living in medicine by taking only so few cases as to make an exhaustive study of each patient.

"The demand of the laity for a quick palliative in order to return to the accustomed work.

"Indisposition to teach clientele the principles underlying homœopathic therapeutics and to make public the remedies given."

Dr. Harvey Farrington, son of E. A. Farrington, who needs no praise from me before the American Institute, is "a chip off the old block." His reply was brief and concise, and is as follows:

"1. Commercialism in medicine. Money may be made more easily by the use of nostrums, crude drugs, alkaloids and other palliative measures.

"2. Materialism which affects both physician and patient. It

is difficult for men to believe that anything which they cannot see, taste or smell will help them.

"3. Tradition. The teaching of our colleges form to a certain extent the idea of the student; the people expect a long bottle and nauseous taste because that is what their forbears had.

"4. Prejudice,—really an outcome of the three preceding causes and stifles all unbiased investigation."

Rudolph F. Rabe, professor of materia medica in the New York College, than whom there is no more clean-cut, consistent, earnest and scientific exponent of true homœopathy, anywhere, gives his answer concisely as follows:

"1. Indifference of the profession itself.

"2. Indifference of the public in consequence.

"3. Confusion as to what constitutes homœopathic practice.

"4. Increasing aversion to be bound by sectarianism.

"5. Lack of official recognition of homœopathy.

"6. Scepticism of medical students in general.

"7. Advance of surgery into the domain of medicine.

"8. Hygiene and preventive medicine in general.

"9. Serum and vaccine therapy in all its phases.

"10. Simplicity, yet difficulty of real homœopathic practice.

"11. Poor financial return.

"12. Modern tendency to disregard principle for its own sake.

"13. Combination tablet evil.

"14. Lack of real harmony in homœopathic teaching in the colleges.

"15. Lack of real homœopathic practice in homœopathic hospitals."

Dr. C. E. Fisher, who got me into this scrape, he who is always ready and able for a fight for the right, but always good-natured and smiling withal, one of the ablest and most fair-minded of homœopathic physicians, has this to say:

"Of the obstacles to the progress of true homœopathy it may be pretty well summed up, in my mind, to the commercialistic spirit of the age. There does not seem to be breathed through the profession that old-time sense of earnest devotion to the principle which characterized the early homœopath. Real students of science these days are few, except as science applies to mechanics and tangible entities. Men are thinking along lines of money-making and political and mercantile achievements as never before. The contagion of the silver eagle has extended



from steel magnate to his physician, from coal baron to his doctor, from the money trusts to the medical men of the day, and real science in medicine, except as it is followed by savants paid by universities or great institutes, is neglected and allowed to pass unthought of as a science, as a thing to be loved, to be studied for its merit, to be fostered and developed as a specialty.

"This last word, 'specialty,' brings the thought more concretely to the fore. Medicine has been divided into specialties as never in old days. Every organ and many of the tissues of the body have been specialized, until the family physician no longer exists except in special cases and fields. Specialists naturally think, study and work along lines devoted to their specialties. This naturally narrows their field of vision in relation to the general science and applicability of medicine. Hence, a good part of our really able men have no earnest care or sincere desire for the general problem of therapeutics. And while it is pre-eminently true that the science of homœopathy should address itself with particular force to each and every specialty, as possessing special value in every special field, over and above any other 'system' or 'school' of practice, specialists as a class have not yet been brought to so view it. The practical elimination from their fields of work, each a part of the human field in itself, has appeared to indicate that homœopathy *per se* has but the limited range of usefulness of the small proportion of remaining general practitioners, whereas it has a particular applicability to the special field of every class of specialists in the great field of medicine did they but know it.

"The modern trend of medicine is just like the ancient trend—toward tangibles. The ancient doctor wanted dried frogs, the skins of reptiles, the livers of dogs, and, later, when tinctures, fluid extracts and gums and resins came in vogue he wanted these in quantities to be weighed, seen, handled, felt and measured. And the public wanted its money's worth in bulk. To-day it is little different as to tangibilities. The vaccine therapist, the antitoxinist, the accepted scientific and advancing therapist along lines most known to the public, must weigh, count and estimate his dosages in figures and material bulks, whether these be pounds or millions of units, and in this homœopathy does not appeal, since its potentials are hardly to be thus calculated. If we could get away from this idea of fixed

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materialisms our ideas might meet with more general acceptance.

"But a positive prohibitory practice has, unfortunately, grown up among ourselves. It seems to be the fashion to feel that homœopathy needs explanation, apology and support. The proportion of physicians classing themselves as belonging to the homœopathic school who make any strong pretense to follow that system alone is very small. I think, of this there can be no doubt. This is a real obstacle to our growth and development. Unless we are wholly honest as homœopathic doctors we cannot expect the people to see any great difference between us and others, therefore between our system and others. Consequently it will not grow upon the public mind as possessing specific values and tangible worth over others. This fault lies with us or with *it*. Either it is faulty and will not meet our requirements, is too limited in range of applicability and saving power to cover the field of therapeutics, and therefore has no rightful place in the great field of medicine as a separate and distinct therapeutics entity, or we are untrue to our own best interests and are not proper guardians of the welfare of a meritorious proposition in the field of science which should be nurtured and cared for for its own real worth."

Doctor J. H. McClelland, one of the best all-around men of our school: he it is who has made of Pittsburg the best homœopathic city in the United States, and to whom more than to any other force is due the establishment and high character of the Homœopathic Hospital of that city, says:

"In reply to your inquiry of February 29th, which I have overlooked until this time, let me assure you that one of the main causes which retards the spread of homœopathy is the indifferent attitude of its practitioners. They do not have sufficient esprit de corps but rather assume an apologetic air for their beliefs and for their practice, and this destroys the confidence of the people and the general profession.

"Another potent cause, to my mind, is the general tendency to use palliatives and handy pharmaceutical preparations which are forced upon them by the large manufacturing pharmacies. The temptation to give a palliative rather than to sit down and study out the exact homœopathic remedy is too great for many so-called homœopathic practitioners."

I quote next from Prof. J. T. Kent, one of the best known

and successful, in a scientific and homœopathic sense, teachers of the principles and practice of the science of therapeutics in this or any other country. He writes:

"If the colleges would teach Hahnemann's *Organon* and compel all the professors to conform to that teaching; if our professed homœopathists would prescribe on the totality of the symptoms, including the pathology instead of 'on the pathology'; if physicians would give the single remedy in potentized form instead of in physiological doses; if they would study the *Materia Medica* to learn what is 'strange, rare and peculiar,' as Hahnemann taught; if they would make constant use of the repertory in prescribing; if they would wait on the remedy after the patient has begun to improve and continue to wait so long as he is improving; then would our cause flourish and increase in numbers and good works."

These quotations from such eminent physicians leave little for me to add, therefore I will be brief in closing this paper with my own views on this very important subject.

To my mind, the chief causes retarding the spread of homœopathy are:

*First* and chiefest, Indolence. We are all naturally lazy, and work only when we are compelled to work by some selfish motive. We seek ever the line of least resistance. This causes the second:

*Lack of Knowledge* of *Materia Medica* and Therapeutics. There is no royal road to even a fairly thorough knowledge of these two subjects. Only by hard and persistent work can such knowledge be gained *and retained*.

How many of us here to-day know the distinguishing symptoms of 100—of 50—nay, of 25 of the thousand remedies of our *Materia Medica*? But if we do not know them, how can we expect to recognize them when they are presented to us? We can pick a friend out of a crowd because we know his features, but we cannot do so with a stranger of whose peculiar features we know nothing.

This lack of knowledge in turn leads to lack of success in curing the sick, and this leads to lack of confidence and faith in the science; and this in turn makes enthusiasm impossible. But without enthusiasm, mastery of our difficult *Materia Medica* becomes an impossible task. The inevitable result is resort to happy-go-lucky routine prescribing, anodynes, purgatives



and any and all makeshift measures without shadow of science, or hope of success above ease and dollars and cents.

Another potent and lamentable obstacle in the path of homœopathy's progress is the too common working at cross-purposes by members of our college faculties. It is a well known fact that in many cases when the professors of *Materia Medica* and clinical medicine may be conscientiously and earnestly to the best of their ability teaching true homœopathy, other members of the faculty make a practice of sneering at and belittling their teachings. I know whereof I speak, for I had such an experience, and fought such a fight for nearly twenty years—while professor of *Materia Medica* and Clinical Medicine in the, at that time, largest and most successful college of our school in the world.

All that saved my life was the fact that in the medical clinic I had opportunity of applying and demonstrating practically the truths set forth in my didactic lectures. Thus, the students had opportunity to see for themselves the often apparently marvelous results of conscientious application of the science of therapeutics, and I had the students with me. But the never-ending, thinly-veiled sneering of some of my colleagues at my efforts to teach the true practice of homœopathy, had a baleful effect on some of the students, and often discouraged me almost to the point of giving up. To my knowledge the same situation exists at the present time. A professor of *Materia Medica* in one of our leading colleges to-day, for whom, as man and physician, I entertain the highest regard, expressed himself thus to me on this subject recently :

"Personally, I am tired of the whole thing and rapidly losing interest. It would not take much to cause me to throw it all over and confine myself to private practice entirely. To engage in teaching homœopathy and its *Materia Medica*, as I have been doing for a number of years, while intensely interesting to me, is nevertheless a thankless job. But two or three students in each senior class ever care a continental about real homœopathy and I have become pessimistic enough to ask, 'Is it worth while?'"

And I have often felt the force and truth and bitterness of every word he utters.

Students love to get the professors by the ears if they can and ask questions of one teacher on subjects pertaining altogether to another. It should be a hard and fast rule in every

college faculty that all questions asked by students be referred to the incumbent of the chair teaching the branch of study to which the question pertains. Strict observance of this rule would do away with this very serious obstacle in the way of homœopathy's progress.

Nothing so discourages an earnest student and destroys his confidence in his teachers and what they teach as conflicting opinions from his teachers on fundamental subjects.

Another great difficulty is the fact that a majority—a large majority—of students entering upon the study of medicine have as a governing motive, not love for the profession nor love for science, but as an easy and respectable means of earning a livelihood; and their chief aim and concern in their studies are, not to master thoroughly the science that will best prepare them for the all-important duty of conserving health and healing the sick, but how easiest to pass the examinations and obtain a diploma and license to practice. After which their main concern is, not to further earnest study and conscientiously apply the science of therapeutics, but how, in the easiest way, to get and keep a practice and make the most money in the easiest way, regardless of the ultimate good of the patient. How much will such physicians advance, and how much will they retard, the cause of homœopathy.

The blight of the curse of the modern craze for and love of money is upon them, and love for science and desire for true success in their noble calling is smothered by the desire to make money. The fire and zeal of the pioneers of homœopathy they know nothing of; they retard rather than forward the cause.

Nor should they bear all the blame. Their college professors must share it with them, for many of them are tarred with the same stick. The stream is not purer than the fountain!

*The Remedy.*—Having thus imperfectly diagnosed the malady, how can we cure it? This is a most difficult question. To obey the first axiom in medicine—*tolle causam*, it will be necessary to do the impossible—change human nature! Remove indolence; destroy selfishness—the first and strongest law of nature; displace cupidity and love of money with the love of science and humanity. With society constituted as it now is, these things cannot be done.

What we can do, however, is to see to it that teachers in all branches of our college curricula have the good of the cause

earnestly at heart. See to it that they know homœopathy. If they really know it and the wonders it can accomplish, and if they are earnest and broad-minded men, they cannot be otherwise than enthusiastic teachers. And, being so, they cannot but inspire a like state of mind in the better of their pupils.

In brief, the first great need is thorough knowledge, which begets success and faith and confidence, which in turn beget enthusiasm; and these all together will overcome inertia and indifference, which are the chief causes retarding the progress of Homœopathy.

Simplification of the study of *Materia Medica* would greatly help do away with a serious obstacle in the way of the spread of homœopathy. As it now is to a beginner, our *Materia Medica* is appalling. Few will undertake it seriously with a hope of mastering it. After more than forty years of its study and practice, I am more and more convinced that the characteristic or "key-note" system is the best way to teach and learn *Materia Medica*, so as to obtain and retain a working knowledge of the greater number of remedies.

I know this proposition will arouse much opposition; the method I advocate will be called prescribing on one symptom, or at least on less than the totality, or "symptom-chasing." It surely is symptom *hunting*. As our *Materia Medica* is at present its study can be nothing else than that. It is by "symptom-chasing" that *Materia Medica* is made—observing and recording symptoms produced by drugs we "chase" and find these symptoms and record them. When a patient presents himself to us for relief from pain or sickness we at once proceed to "chase" and find the symptoms peculiar to his particular case. There is no other way to practice homœopathy in accordance with the law.

Further, it is impossible—not only impracticable, but impossible—for a physician in general family practice to make every prescription on the totality of the symptoms—the ideal way. He hasn't time, but when one is familiar with three or four *characteristic* symptoms of each remedy, he has a good working basis for an accurate prescription.

If one is familiar with, say, four characteristic symptoms of *lycopodium*, for example, as aggravation of all symptoms between four and eight P. M., pain in the renal region aggravated by retaining urine, and relieved by passing urine, red sand in urine, sense of satiety immediately on taking a little



food, even when beginning to eat with good appetite; it will be altogether useless to seek further; lycopodium is the remedy.

Every remedy has a few such characteristic symptoms, if we only know them; and when found, in ninety-nine cases in a hundred the remedy to which they belong will be the one for the patient. In the one hundredth case it may be necessary to study up the totality of symptoms by repertory or otherwise. I have verified this fact in thousands of cases, and earnestly recommend the method as the best and easiest way to minimize the discouraging task of acquiring and retaining a usable knowledge of *Materia Medica*.

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### A RESUME OF OFFICE CASES.

BY

J. ROSS SWARTZ, M. D.

(Read before the Goodno Medical Society, York, Pa., June 13, 1912.)

IN offering the following suggestions relative to routine work, confined principally to hours in the office, I have no apologies to make by reason of the academic nature of the subject matter, for the reason that many of our new patients are secured from the hands of other physicians and, in a manner common to the laity, we are "tried out in this way," so if we are fortunate enough to satisfy our newly-made acquaintances, the chances are in our favor that they will return and, having found something good, will bring others with them. A reputation established on these lines is seldom lost and is the only stable source of any reputable physician's success.

A case of "Nerves" presents itself, so diagnosed by the patient and given her by a former attendant. She has a dry, jaundiced and abundantly wrinkled skin, yellow conjunctivae, sighing respiration, fidgety movements preventing her from sitting quietly before you, constantly wetting the lips and jerking out her words in interrupted description. Close questioning will elicit much discomfort occasioned by tumultuous rumbling of gas through the intestines; the abdomen is distended from fermented intestinal substances, frequent urging to urinate, at times urine scanty and dark in color, again large amounts of colorless urine will pass; some pain is complained of across the lumbar region; cold feet and aching calf muscles, probably some rise in temperature. inability to fall asleep or un-

able to remain asleep for any length of time followed in the morning by hard pains in the head accompanied by a degree of nausea. This patient will tell you that she has been treated for her nerves, for neuritis, for nervous sick headache, for malaria, for change of life and all that pertains thereto.

Personal experience has proven that in preventing such a patient from proclaiming her own or someone else's diagnosis, I have gained my first point, that my judgment of the case is not swayed by an opinion and by holding the history to present conditions and facts, I am free to judge the better. Examination will disclose low ocular tension, tongue coated, large and flabby, indented and serrated, buccal cavity pallid, inelastic skin and flabby muscles, rapid heart with frequent interruptions, tenderness on pressure over the region of the liver but more decided over the duodenum and stomach pit, lower abdominal area tympanitic and enlarged, urine loaded with debris and if examination is pursued indican will often be detected, at times some swelling of ankles, pressure over calf muscles develops a degree of pain and soreness. Your patient will furnish you the details of a breakfast of rapidly prepared oatmeal and weak coffee, usually egg in some form, maybe the effort to consume fried food of some sort, as many of these patients have abnormal cravings. As a result the balance of the day is spent in ineffectual effort to secure relief of noisy eructations caused by gaseous distention accompanied by absolute disgust of any kind of food.

Many remedies suggest themselves to one having before them such a case, but few are required to often change the entire complexion of such conditions, as will be exhibited to you at a subsequent visit. The first and all-important problem is to recognize faulty metabolism; to dislodge poisonous digestive products by arousing the kidneys to activity, clear off accumulated mucous on the stomach membrane, stimulate intestinal secretion, reduce arterial tension and secure skin transpiration. Suggest the juice of a half a lemon in a cupful of water brought to boiling point and drunk about a half an hour before breakfast. Forbid the use of starches, oatmeal, for instance, unless thoroughly cooked over night; sugars and fats, except butter should be proscribed. The condition of hyperchlorhydria is soon overcome by the excess of acid advised before the morning meal and repeated again, preceding an excessive indulgence in food if required. Milk in half-glass portions to which a small amount of

salt is added should be partaken of every two hours; both for nourishment and the benefit derived by flushing the kidneys. A large glass of cool water before retiring at night aids materially along similar lines.

The medicinal treatment is confined usually to mercurius dulcis if bowels are sluggish, pushed until there are positive evidence of bile in the discharges from the bowels; mercurius sol., podophyll., eupatorium or chelidon., if there is a disposition to loose, frequent, scalding but scanty movements.

The large, thinly coated, flabby tongue will suggest mercurius sol.; thin, yellowish, scalding stools, podophyll.; soreness of calf muscles, chilliness, etc., eupator.

The many characteristic symptoms are passed over for the sake of brevity as I am aware they are all so well known.

The disturbances caused by fermentation are corrected by the use of creosote or nux vomica; indican being present in the urine as a result of putrefactive albuminous fermentation, is readily controlled by properly selected articles of diet.

The conditions enumerated are not rare and at times refuse to yield as promptly as we would wish when numerous suggestions and a more diversified complement of remedies are demanded. The object is to outline in a limited manner, the course usually pursued. The prime object we hope to attain is to establish more rapid digestion in order to prevent the auto-intoxication which, without doubt, is the cause of the symptoms of a typical case.

Now you have ushered into your office one complaining of sore throat, painful muscles, headache, a general languor, some alleged impairment of the large joints with slight rise of temperature. On inspecting the throat, enlarged tonsils of minor degree, but of positive dryness and darker color than normal, the tonsillar and pharyngeal membrane studded with a deposit like tallow and slightly elevated above the surface, will be present; the tongue slightly coated with edges reddened and angry in appearance, bowels are sluggish and secretion of urine scanty and scalding in passing. If any attention has been given by the patient, a brick dust deposit will be detected when the urine has cooled just preceding or after an attack.

The mercurial preparations are not often indicated and are less efficient than guaiacum, phytolacca, rhatany, kali bichrom., or sanguinaria.

A gargle of borax and glycerine dissolved in hot water, used cool, will afford comfort as all these discharges have



an acid reaction. The addition of potass. citrate to the water drunk will aid in eliminating the gouty condition rapidly.

Our third patient is the true neurasthenic, the post-operative neurotic, who has been plucked by the surgeon and is passed up to the home physician to toil with, to pour out to him tales of distressing symptoms and now your trouble begins with the fugitive pains limited only to the entire body area, accompanied by expressions of suspicion that permanent relief cannot be secured; the tale of sleepless nights, the irregular, tumultuous heart action, shortness of breathing, torpid bowels aggravated by intestinal distension, the gulping up of volumes of gas, are but a few joyous morsels handed out to you about the time you hope to escape to witness a game of ball or are anxious to have the privilege to listen to the next patient, less trying and probably more interesting. But she is here and must be endured for she needs help. Consider sumbul., scutillaria, picric acid, magnes. phos., asafoetida, moschus, also take into your confidence passiflora, but under no circumstances use narcotics. Electricity and massage are adjuncts and worthy of use. Endeavor to use forced feeding, preferably in liquid form, milk, butter-milk, thin soups deprived of all fat, little at one time but repeated often.

Von Noorden in his work on Colitis, a condition almost always associated in those cases, is not convinced whether the nervous outbreaks are the cause of or are the result of the copious discharge of mucous passed by the bowels. His advice is to use high enemas of olive oil to which oil of tar has been added and retain throughout the night. The cabinet baths are very comforting if not used too long or too frequently. Urge such patients to arise for breakfast and if weary, take rest at various times throughout the day. The use of hot milk will assist in the control of many annoying symptoms.

I have the honor to submit for your consideration the foregoing brief, principally to emphasize the importance of advising our patients that the comfort sought is largely dependent upon good wholesome food, well selected; that the dieting is quite as essential as the prescription you may offer, and to recall to your attention the fact that the foundation of much of the success of homœopathy in the early days was laid in advising the patients as to what they should eat and what they should avoid; that printed slips were furnished families with the medicine, that they might assist the rapid action of the prescribed remedy. Fewer remedies and consequently greater familiarity with these remedies will be productive of much more successful prescribing.

**INDUSTRIAL SCALPING.**

BY

H. L. NORTHRUP, M. D., PHILADELPHIA.

Mrs. S., age 31, was employed as a scrub-woman in a shirt factory. One morning, October 14, 1910, while on her knees scrubbing, her hair was caught in back by the rapidly moving shaft of a dynamo and she was completely scalped. There was very little pain at the time of the accident. When I say "completely" scalped, I mean that the line of cleavage occurred just above the eyebrows, extended around the head close to the auricles, and included the entire occipital region. This large area of scalp tissue was completely avulsed and the bone was exposed and denuded of its periosteum in the frontal region. The accompanying photograph will give an idea of the area involved. (Fig. 1.)

This patient was not rendered unconscious, but was badly shocked and was hurried to Hahnemann Hospital. The ambulance surgeon, Dr. J. Hunter Smith, picked up her detached scalp from the floor of the factory, put it in his coat pocket, and when he reached the hospital sewed it in place with several silk-worm sutures. It did not unite, and in a few days had to be removed because it had become gangrenous and the patient exhibited signs of both local and general sepsis. After the septic condition had been controlled I had her etherized for the application of Thiersch skin-grafts, which I removed from the front of one of her thighs, and at this sitting I covered more than half of the raw surface on the top of her head. All but one of these grafts adhered and "took," and three weeks later I repeated the operation and grafted the rest of the raw surface. Several small granulating points persisted, as they do after every skin-grafting procedure, and were treated with boric acid powder, aristol, and scarlet "R" ointment. The condition of the scalp existing to-day is well illustrated by Figs. 2 and 3, and by the patient whom I present to you to-night. The new integument is thin and rather tightly adherent, but now, twenty months after the accident, it is becoming more and more pliable, more like normal integument in appearance and structure, and sensation is rapidly extending upward on all sides toward the vertex. The area which is still anaesthetic is as

large as the palm of one's hand. She tells me that sensation is gradually extending into this area. Ultimately the entire new covering ought to and probably will be sensitive. The patient herein referred to now wears a wig which she naturally considers a rather poor substitute for her own original "crowning glory," but in this particular instance she feels that nature unadorned is not adorned the most, and that art must come to nature's aid and cap, not alone the climax, but also the vertex.

It must be conceded that here is another triumph for



FIG. 1.—Showing the Extent of the Denuded Area.

Thiersch skin-grafting, inasmuch as no other means except Thiersch grafting, or perhaps whole thickness grafting, could have cured this denuded head and saved this woman's life. In many other parts of the body large raw surfaces, perhaps after much patience and coaxing, finally cicatrize, but that the entire cranial wall, stripped of its integument, could completely and successfully cicatrize, is inconceivable. In fact, history proves that such healing is impossible.

The subject of scalping is an interesting one. The youth of our land read with dime-novel enthusiasm of the North



American Indian's method of securing his human trophy and of proving his prowess in battle. Scalping was practiced not only by the American Indians, but also, in early times, by most of the savage and barbarous nations of the Eastern Hemisphere, viz., the Scythians, Gauls, and other wild peoples of Asia, Europe and Africa. Sometimes the whole head was taken in lieu of the scalp. Indeed, our own American colonists



FIG. 2.—Present Condition. Rear View.

practised scalping, and offered a reward for the scalps of the enemy. In 1724 the Colony of Massachusetts offered 100 pounds (\$500) for Indian scalps. Thirty years later, during the French and Indian War, the French offered a bounty for British scalps, and the colonists for Indian scalps. In 1755 forty pounds sterling (\$200) was offered by Massachusetts for the scalps of male Indians over twelve years of age, and twenty pounds (\$100) for the scalps of women and children. The area of scalp removed varied from a piece of the size of a monk's tonsure to the whole scalp.

While belligerent scalplings have decreased in number with the development of civilization, industrial scalplings still and

will occur, just as long as women are employed where machinery and its shafts and belts are found in our factories. All subjects scalped by machinery have been females except one, a Chinaman, whose queue was caught in a revolving machine and he was completely scalped.

The mechanism, or *modus operandi* of the accident, is the pulling of the hair and scalp in one direction by the power and



FIG. 3.—Present Condition. Front View.

speed of the machine, against the weight of the body and the struggles of the patient. Of course, violent, quick traction is necessary. The tissues of the scalp do not part until their elasticity has reached its limit, when the skin tears, the line of separation usually occurring at the junction of the scalp with the skin of the face and neck, i. e., where the skin is thinnest.

Davis (*Annals of Surgery*, December, 1910) reports a series of experiments made by Fouchard with the following results:

In the first series violent, sudden traction was made on the scalp in the direction of the median axis of the body, by means of the plaited hair. Three attempts resulted in the tearing out

of nearly all of the hair in each instance, without injury to the skin. The fourth, where the traction was not so strong and less sudden, produced no result.

The second series of traction was operated in the same way, but the pull was made obliquely from back to front. Three attempts were made with a negative result in each, except for a limited tearing of the hair alone at the periphery of the zone of implantation.

In the third series, five experiments with traction from front to back produced five scalplings, two complete and three incomplete. The tearing in each case began at the superciliary ridges. Fouchard concludes that the tearing of the scalp is produced by a sudden and violent traction, which is applied obliquely from front to back. The superciliary ridges act as the cutting instrument, and the skin is cut by them where it is thinnest, and the tearing follows toward the neck. He says this is the usual method in the actual accident.

Davis further states that 90 cases of industrial scalping have been reported, of which 80 were complete, the entire scalp having been divulsed, and ten were incomplete, in which the area involved was smaller and the scalp was not completely separated from its attachments, but hung by a pedicle.

The separation between the tissues usually first occurs in the fascial layer beneath the aponeurosis of the occipito-frontalis, but occasionally the rupture goes deeper and the periosteum is ripped off to a greater or less extent (as in my personal case which I report in this paper) thus exposing the bone of the calvarium.

By the enforcing of certain rules and the enacting of a few simple laws, many of these accidents can be avoided. Machinery in factories, especially belts and shafts, should be housed in and female operators should be compelled to dress their hair close and snug, and to wear a closely fitting cap while in the work-room.

The symptoms precipitated by even a complete scalping are very few, and seldom need any special care or attention. It seems incredible that pain is so slight, or even entirely absent, the loss of the scalp not being realized until the patient places her hand upon her head at the time of the accident. Several hours later, and during the redressings especially, however, it may be exceptionally severe. My patient complained bitterly



and almost convulsed with agony during the early weeks of her convalescence, when her dressings were changed.

If the size of the wound and the vascularity of the scalp are considered, one would expect free and serious hemorrhage after a scalping. But such is the exception and not the rule. When it does occur serious anemia and death may follow. In fact, hemorrhage is about the only cause of immediate death in these cases. Whether the hemorrhage is profuse or not, shock and collapse may occur and demand energetic treatment.

But most of the complications develop during the period of convalescence, which, it is unnecessary to say, is a prolonged one. Aside from the difficulties associated with the treatment of the wound, the patient is very apt to become septic, this condition being made easy by the anemia and recent shock, the suffering and the presence of a free discharge of pus from so large a raw surface. Formerly sepsis, with erysipelas and phlegmonous inflammation complicating, was commoner than it is to-day because of improved modern surgical technique. Tetanus has occurred several times after scalping, and mastoiditis is an occasional complication. Septic pneumonia also has occurred. To avert sepsis, therefore, the wound must be cared for assiduously and intelligently, and the patient's suffering must be reduced to a minimum, while the general nutrition demands every thought and care. If very much cicatricial contraction of the new cranial covering takes place, which is particularly prone to occur if grafting has been postponed, or has failed, and the raw surface has partially cicatrized, the eyebrows and lids are especially apt to suffer distortion and elevation, with the resulting change in the subject's facial expression. Under these circumstances it may be impossible for the patient to close the eyes and a lagophthalmus exists. Fortunately for my patient, none of these complications developed to hinder her complete recovery or to interfere with her good health, although it will be remembered that she manifested a pronounced septic tendency during the first two weeks after her accident. But this was promptly controlled by faithful care of the wound. To be sure she feels the local effects of the injury, evidenced by coldness of the top of the head and obstinate "sick headaches." The latter, however, are now lessening in frequency and severity. Theoretically, the tighter the new scalp covering, and the more pronounced its departure from normal skin, the more marked will be the various subjective symptoms and the greater the tendency for the new covering to

crack and break down, or ulcerate. Until recently there has been some disposition upon the part of my patient's new scalp to ulcerate over the vertex, but every time this has happened a little scarlet "R" ointment, followed by the use of calendulated boric acid powder, have promptly restored the integrity of the skin.

Sensation of the new surface extends slowly and gradually from the normal integumentary margin upward toward the vertex, different cases varying greatly in the rapidity and degree of this sensory nerve-supply. Some remain anaesthetic for years. This lack of sensation has been the cause of infection and ulceration in several instances. Davis reports one case where the patient ran a hat-pin through the grafted area without being aware of it, and infection followed. Hence the patient must be instructed to exercise every necessary precaution to avoid such accidents.

A consideration of the treatment of scalping accidents may be summarized in a few words. If the torn scalp is still attached by a pedicle, an effort should be made to save it by suturing it into place, when possibly its circulatory vitality will be re-established and it will live. If the scalping has been complete it is useless to suture and to try to save the scalp, as was done by the hospital resident in my personal case. No instance of a successful result and a restoration of the circulation of the scalp has ever been reported where this has been done, although the scalp has been replaced in 21 cases. And even though the scalp is still attached in some portion of its continuity, it is likely to become partially or completely neurotic which, of course, will necessitate its removal.

To permit, or to try to get these wounds to heal by granulation and cicatrization is censurable, therefore some method of skin-grafting must be employed. The Reverdin, zoödermic and heterodermic methods are not, for individual reasons, the best, and this leaves only the Thiersch method to be used, as the most universally successful autodermic plan in vogue. As stated previously Thiersch's grafts were used with very satisfactory results in the case herewith reported, and although my patient may think that I speak ironically, I do not when I congratulate her upon her bald head.

Davis recommends the application of whole thickness grafts, sections of integument taken from the thighs and from whose under surface all fat has been removed. He claims that there

is greater elasticity of such a covering, better vitality and less likelihood of ulceration. I have not yet had a chance to try it. Should another case of complete scalping be presented to me I intend to carefully cleanse the avulsed scalp, shave off its hair, divide it into sections of convenient size, and preserve these sections in cold storage until the raw surface is ready to receive them. I believe that such a plan is quite feasible, it will obviate the necessity of removing grafts from the patient's thighs, and will possess the additional merit of laying the foundation for a hairy scalp.

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### PREPARATORY AND AFTER CARE OF SURGICAL CASES.

BY

MARY DAVIS RIDGWAY, M. D.

(Read before the State Medical Society of Pennsylvania at Bedford Springs, Pa.,  
September, 1911.)

THE word operation conveys a thrill of horror to many medical practitioners and the laity. What is the reason? It is the uncertainty of recovery and if recovery, the frequent unsatisfactory recovery. It is the surprises and the unexpected in surgery which carry terror to every heart, and to avoid these more attention must be given to the preparation and after care of our cases.

Every community cites a case of a fine specimen of man or woman who underwent an operation with assurance of recovery, only to be shocked by the news of unexpected death. Who has not heard the expression, "The operation was successful, but the patient dies a few days after."

Many medical men are criticised for not referring cases, but when they compare the unsatisfactory recovery with the case they have kept alive by constant care, they feel justified in not sending them to the operating table.

The purport of this paper is:

(1) To demonstrate to the medical practitioners that they can refer their cases with safety.

(2) That success of operation and recovery depend largely upon the medical practitioners, because they have the treatment of cases, "Before and After," thereby having the best of the bargain.



The success of surgery is gauged by the return of strength and the length of time necessary for this.

(3) To demonstrate to the surgeon that by systematic, careful observation "Before and After" operation the mortality rate is materially lessened, the horror and pain of operation are avoided.

Many of the unfavorable and fatal results rest with the medical practitioners. These could be avoided if they would begin treatment along preparatory surgical lines as soon as they suspect that there might be a possibility of operation, if the inflammatory symptoms do not subside.

This general preparatory treatment would in no way interfere with the treatment of the disease.

Lack of preparation of desperate cases which are brought to the surgeons as a last resort when the patients only have a few hours to live, has been the cause of the world-wide censure of surgery and surgeons.

The length of the period of preparation may vary from one hour to six months. The time given depends upon the nature of the case. The longer time given to the preparation, the shorter and more satisfactory the convalescence and recovery.

In all cases, a complete, previous and family history and present conditions should be taken, so as to know what we may have to contend with and treat, for the conditions present, previous to operations are often aggravated in the extreme afterwards. The knowledge of these conditions aids in post-operative prescribing. A thorough examination of lungs, heart and blood vessels should be made, also a blood count taken to corroborate the diagnosis or aid in arriving at the diagnosis. A thorough examination of the urine should be made, also history of the condition of the bowels.

*The treatment of a twenty-four-hour preparation case.*

Place patient in bed.

Give liquid diet every two hours and register amount.

Give six glasses of water in addition to the liquid diet.

Give the indicated remedy, apply hot water bag to each kidney continuously.

Collect twenty-four-hour specimen of urine, examine, paying great attention to the amount of urea. If it registers less than 250 grains in twenty-four hours, it is not wise to operate, the normal amount being 375 to 480 grains. The more nearly you can raise the urea to the normal amount, the more success-

ful the result of operation. In many institutions albumen and other tests are considered to be of more consequence, but to me the urea test is most important. Do not set the date of operation until you know what the urea examination is, excepting in emergency cases, for many times an added day or two of treatment will raise the amount of urea and stimulate the general circulation of the body so that there is little risk in operating. Many cases may be prepared at home, while with others it is necessary to place them in a hospital to insure proper rest, treatment and separation from the family. Empty the bowels usually with a high enema, the night before and the morning of operation. In cases of long preparation, mild cathartics may be used. Avoid the drastic effects of drugs, the day or night before operation, because of the excessive prostration accompanied by the loss of sleep incident to frequent evacuation.

If the preparatory care is more than twenty-four hours, I do not insist on liquid diet, but restrict beef or anything made from it, potatoes, fried things and ice cream. Do not allow cold water to be taken within an hour of meals, but give six or eight glasses daily, two or three of which contain five grains of cystogen in some form. In stubborn cases, when the indicated remedy does not accomplish the effect desired, I have had excellent results as an intercurrent treatment from teaspoonful doses daily of sweet spirits of nitre. In other cases, cream of tartar, one teaspoonful to a quart of hot water and give one or two glasses daily, cold, or Basham's mixture, one or two ounces every four hours, or a high saline enema, will start the kidneys to acting and when once started it is easy to keep them going with the indicated remedy.

In case of a cold and congestion of the kidneys, a flaxseed poultice applied once or twice daily will accomplish much. Some cases may require this treatment four or five days. Kidney packs accomplish more than blanket packs and without the prostration and excitation of heart, and less danger of exposure and subsequent cold. Employ the remedy which has the greatest diuretic value and at the same time controls the nervous situation, as Cup. ars., 3x or 6x, Puls., Ipecac, Veratrum. Sometimes Acon. or Bell. By having the nervous symptoms under control, better elimination by kidneys and bowels is accomplished and reaction is quicker. Give gentle stimulation.

such as strychn. sulph. 1-60 every six or eight hours by mouth or hypodermically, if the stomach is intolerant of medicine.

By this careful preparation you allay the anxiety of the family and this feature means much, not only to the surgeon and nurses, but to the patient. In facing an operation the patient has two powerful forces at work. The one, thought of personal safety. The other, the thought of bringing anxiety and grief to their family, which may be endless if they do not recover. By more thoughtful attention you can avoid their mental anguish and strip the word operation of some of its dread. Many a patient would decide to have operations which would mean cure, and thereby affect the happiness of many lives. In the abstract, the loss or saving of one life does not sound to be much, but its far-reaching effects and influences are a great consideration.

The question naturally arises in the medical practitioner's mind, "How can a surgeon treat a case for a long time previous to operation?" It is not a surgeon's province unless the patient comes to him primarily. It is the duty of the medical practitioner to present the case to the surgeon with his full knowledge of the case, and the patient in as good condition as possible. It is the duty of the family physician, if he suspects any surgical conditions, to possess himself of definite knowledge of the excretions. Many cases come under the attention of a surgeon, which have not been referred. We call these chronics or rounders, going from one doctor to another. They have all kinds of affections, from hemorrhoids to fibroma, but their physical condition is such that physicians have discouraged their being operated because their heart would not stand it. The most frequent case is the woman who needs a cervical and perineal repair and is nearing the menopause. Two extremes are met. The emaciated, wiry, nervous, hysterical woman with mental disturbances, whose skin is sallow. The other is the woman who has put on added weight, some doubling it. This woman is bloated, but it is hard to convince them, because they do not think a person is bloated unless a dent can be made on the skin of the leg which remains for a short time. She is short of breath, has palpitation, vertigo, cramps in the legs, may or may not have indigestion. By registered amounts of liquids taken, insistence upon the diet and registering elimination, this patient loses this bloat and disturbing symptoms and is a favorable subject for operation. The ema-



ciated case, by having the same method applied with different prescribing, will reach a condition to be operated on.

Proper diet, proper elimination and careful prescribing will bring the patient to the happy medium. In other words, the fat person becomes normal and the emaciated one normal when they take food that assimilates and get rid of the waste. There may be some cases which need slight variations in the diet, but this rule has worked admirably for me. I have known of several cases of Bright's disease, some bloated, some emaciated, going safely and comfortably through an operation with two or three days' preparation, when the amount of urea was brought up, but I advised longer period of preparation wherever possible.

We should give special attention to the preparation in cases of large fibroma and cysts, where the patient is much bloated. It is frequently possible to increase action of the kidneys somewhat, but not satisfactorily. The bowels should be moved daily with a mild cathartic. The reason of scanty urine in large fibroma or cyst is often due to pressure of the growth on the ureters, which, when removed, allows the kidneys to secrete. In operations where cocaine is to be used, antidote its general effect by preceding its injection with a cup of black coffee, if patient's stomach is tolerant. If not, give one teaspoonful of aromatic spirits of ammonia to a glass of water and in a few minutes, give four or five drops of spirits of camphor.

The next question is the anesthetics and the anesthetizer. No risks should be taken with an inexperienced anesthetizer. If a resident physician is learning, he should be accompanied constantly by an experienced instructor. With the operation ready to begin, it is not the place for visiting physicians to renew acquaintances and indulge in conversation which is likely to divert the attention of the assistants. Always know that at least two hypodermics are loaded; one with nitro-glycerine, or alcohol, and the other with strychnia, grain 1-60. It is wise to inquire about the readiness of the oxygen tank and the transfusion apparatus. These duties belong to a head nurse, but gentle inquiry occasionally prevents an oversight, because she is responsible for so many people and so many things.

With the patient approaching operation from the treatment standpoint, I will not spend much time on the technique, because this is in the province of the nurse, except to mention that too bulky a pad of wet bichloride on the site of operation for a

night, often lays the foundation of a cold, the greatest menace in surgery, which so often results in either pneumonia or congestion of the kidneys.

It is not wise to allow a patient to lie in a pool of water or cold, wet blankets during operation, which is the result of the patient being scrubbed on the table. Instead of it, the use of alcohol, then ether, followed by iodine on the skin, insures asepsis satisfactorily.

#### AFTER TREATMENT.

Shock, pernicious nausea, ether pneumonia and uraemia are the dreaded afterclaps of operations, which are avoided by careful preparation and efficient after care. I will not deal with hemorrhage in this paper. When the dressings to the wound are applied, the after treatment begins. To avoid ether nausea and great thirst, this year I have washed the stomachs of several abdominals on the table, whose condition was good, using ten grains bicarbonate of soda to the quart of warm water, using four or five quarts of the solution. Sometimes the use of borax is employed in the same way. After the stomach is emptied, two ounces of castor oil is passed down the stomach pump. A little of this may come up, but enough remains down to aid in catharsis.

Before patient leaves the operating room, be sure that a dry nightgown is put on. A safe method to follow is to give a hypodermic of strychnia sulph. 1-60 grain, as the patient leaves the table. It is most advisable to give a high saline enema, or one-half pint of black coffee, plus one-half pint of normal salt solution, plus thirty drops of arnica, while patient is on the table. The advantages of washing out the stomach are the lessening of the unpleasant odor of ether and in many cases it prevents ether nausea, and reduces the thirst.

If a patient is nauseated much after beginning to react, I give a pint of very warm water with ten grains of bicarbonate of soda, which they may or may not eject. In either instance, it is advantageous because the nausea ceases and thirst is absent.

The method of former years of withholding water has been agonizing to the patient.

By changing nightgown on the table, giving stimulation and having the stomach clean, the patient upon being put to bed

does not have to be disturbed, and thereby avoids exposure and exhaustion. Nausea is less apt to occur. In most cases they have a restful sleep of several hours.

If reaction is not satisfactory, place patient in bed and give adrenalin or nitro-glycerin or digitaline or camphorated oil, or brandy, when things look serious. Always depend upon oxygen and as a last resort, employ transfusion of normal salt solution. Do not be afraid to stimulate. Eight hypodermics are not too many to give in an extreme case. Always insist upon a complete hypodermic tray, even if you never have to call for it during your lifetime.

With the patient reacting, place a hot water bag to each kidney, the bed well supplied with heat. After patient is fully reacted, keep hot water bags with small amount of water to each kidney for several days. It is a great stimulant, sometimes raising amount of urine thirty or forty ounces.

Obtain result from a high enema within twelve hours. Sometimes one can be given within eight hours. The ingredients used can be glycerin and water, if the stomach contains castor oil. The safest and surest enema is the high compound, two ounces of epsom salts, two ounces glycerin, two ounces olive oil, sufficient water to make a solution. Be sure that the nurse is equal to giving a high compound and knows if the tube coils upon itself in the rectum. If no result, repeat in four or six hours, elevating the foot of the bed for twenty minutes, then reversing and elevating the head of the bed. If no result from second enema, follow in half an hour with one pint of soap and water enema. Between and subsequent to enemas, pass high rectal tube, so as to control distension if any. If no result, then wait eighteen to twenty-four hours from time of operation and give one teaspoonful of salts every hour until bowels move. Having patient's bowels emptied, accompanied by careful preparation outlined, ether nausea is lessened.

The use of the homœopathic remedy is of greatest value and should be given as soon as patient reacts, continuing during stay in the hospital. Also use heroin, grain 1-24 every two hours, to control pain. Continue hypodermic of strychn. sulph. 1-60 grain, every four hours, for the first day, rapidly reducing the dose. Do not let patient suffer from pain. Never give morphia at any time, because of its bad effect upon the kidneys and bowels. Echinacea in appreciable doses, where infection is present, is valuable.



After reaction give small quantities of cracked ice and after the gas passes, begin laparotomy diet of hot tea or iced ginger ale or fruit juices. Turn patient from side to side every hour or two, which will prevent adhesions. Each day gradually increase the quantity of diet. Give as much water in small quantities as the patient will tolerate. Six glasses if possible. On morning of fifth day soft diet may begin and on sixth day squab or lamb chops are allowed. Gradually increase vegetables with care. Follow same diet as earlier mentioned.

Nothing is gained by hurrying gynaecological cases out of bed under three or four weeks.

If at any time the stomach becomes intolerant of water and condition becomes grave, restrict diet. Give high saline every four or six hours. If eliminations still are scanty, give two ounces Basham's mixture, high every four hours in alternation with saline high. If still stubborn, a high enema of acetate of potash, ten grains to a pint of water every four hours in alternation with saline enema, high. Hot flaxseed packs to kidneys every four hours.

Measure urine daily and have complete examination in serious cases. The greatest precaution should be taken against non-elimination and cold. The amount of urine should be near forty ounces the first two or three days, with an increase ranging from sixty to eighty ounces afterward. By proper elimination of urea, plus other solids, the pernicious vomiting, distension, restlessness, nervousness and delirium with irregularities of the heart are minimized or not present at all, and infection, if present, is rarely troublesome. I believe the normal amount of urine should be from sixty to eighty ounces a day. It is wise to give close personal supervision to the after care, and not thrust grave responsibilities upon a resident physician when he has not had sufficient experience. In every case a special, graduate nurse, for at least twenty-four hours, is advisable. If the case demands it, have two twelve-hour nurses, changing them at noon, if possible, and in very desperate cases, have three. This extreme precaution and attention is only for a short time, and is money well invested. When a nurse of only a few months is often pressed into service during a rush in the hospital, the patient's recovery is jeopardized. In one of the most prominent hospitals in Pennsylvania every ward surgical case is specialized for two days.

Another essential is to preserve the health of the nurses. It

is always absolutely necessary to allow six hours' rest. The extra nurse means only a matter of from five to twenty dollars, thereby often saving a patient, which is cheaper than funeral expenses. Never allow a nurse to remain on active duty twenty-four hours. No one can do good work after eighteen hours of continuous strain. Encourage graduate nurses to take fewer cases and thereby prolong their nursing ability, thus lessening the number who are absolutely unable to nurse after ten years, or who are neurasthenics. By placing them on the race track with death, case after case, and contending with nervous excitement of families, they soon break down. By taking fewer cases, they ought to be able to nurse until sixty with ease and intelligence, instead of arriving at forty, a wreck with no means of support and dependent upon others. It is unpleasant to think of nurses as mental and physical wrecks after having been instrumental in many recoveries and doctors' successes.

#### HOME TREATMENT.

After leaving the hospital, the medical practitioner's work begins. He should keep patient under observation for a year at least. Register daily amount of liquids taken. Register amount of urine passed daily for the first month; then once a week, and later once a month with frequent examination of the same, especially for urea.

A knowledge of the color of the bowel movements is necessary also.

By restricting beef or anything made from it, potatoes or anything cooked with potatoes, fried things and ice cream, and using dark breads and giving the indicated remedy, many unpleasant conditions ranging from irritability of the bladder to melancholia, frequently met with, are avoided. I usually give the remedy three times a day after the first month. I find that gentle stimulation after reaching home for a couple of months is a great advantage. The prostration is nil. Dr. Weir Mitchell is quoted as saying the cases of neurasthenia he has seen after operation should not be called that, but should be named ether cases. I have never seen any bad results from cases where this simple method was followed. In every instance possible, send the patient to the seashore to shorten the convalescent period, because the stimulating effect of the sea air is

invaluable. Two weeks at the seashore is more beneficial than six months in the mountains.

By following accurate treatment, there is no horror in surgery. Take nothing for granted. Shock is a rarity. There is no bad afterclap except in malignancy. The pus case has no dread. The patient rides safely through operation with the meagre preparation I have spoken of, and ordinarily recovers with one high enema a day. Seldom any other treatment is needed outside of indicated remedy.

I wish to emphasize that a cold is the greatest menace to the work. It may not be apparent long, because head symptoms soon subside, but a disturbance later appears as congestion of the kidneys.

The beneficial effect from eliminative treatment upon post-operative cases can be observed when carried into all cases. You will pilot your patients safely through the diseases of childhood, including the fevers and avoiding the many nervous disorders. You will bring more patients through all diseases, especially avoiding the serious disorders that come to men and women at the change of life. You prevent Bright's disease. Most patients are alarmed when they think there is anything wrong with their kidneys. This can be explained to the different classes easily as sluggishness. To the automobilist, you compare the stored up urea to the carbon in the cylinder; to the engineer you compare the choked-up flues; to the cook you compare the choked-up lamp chimney or chimney flue. All of these are perfect mechanisms which will work when the waste is cleared out. The same is true with the human body. With proper elimination and comprehensive knowledge of conditions, a woman at the menopause avoids putting on added flesh or manifesting nervous disorders incident to that time.

With proper elimination, the man avoids falling into one of the four conditions that are so usual now.

(1) Languor, fatigue or restlessness with its consequent debility and impotency which are so many times attributed to wild oats, but are usually a toxic condition. These uncorrected pave the way to Bright's. He may be bloated or emaciated. In business he is known to be running down at the heel or down and out.

From this group emanate three classes: The sitter (or idler), the poor tramp and the rich tramp.

The sitter is seen the world over as a man of good physique



who can never find work and sits around allowing his wife to make the living by taking in washing or sewing.

The poor tramp feels that a change and open air are what he needs; notwithstanding the living is so precarious, it appeals to his mind.

The rich tramp is one who has the same class of symptoms, but is fortunate enough to consult his physician who sends him abroad for the rest and stimulating effect of the sea, with medicine in his pocket which is reconstructive and tonic. Every out-going steamer is laden with this type of case.

(2) Those suffering from excessive sexual excitation or perversion, leaving their homes for other avenues and ruining the chances of being reinstated in their families, if they ever do recover.

(3) Melancholia, when he blows out his brains or the brains of some of his family.

(4) Unbalanced judgment of a trusted employe, such as the bank clerk who reaches over and takes a few thousand dollars, runs the length of his shadow, sits down and is caught, thereby burdening his family and himself with disgrace the remainder of his life.

Its curative effect will be found upon cases who have had some of the following symptoms for years, such as irritability, depression, extreme languor (called laziness), rheumatism, asthma, hay fever, tic douloureux, terrible headaches, angina pectoris, intestinal disorders, many skin affections, hives and chronic procrastination.

Arterio sclerosis will be prevented, also the formation of gall stones, kidney stones and gravel. I believe sixty per cent. of the people in insane asylums are there as a result of non-elimination. Everybody ought to have their urine examined once a month.

Many of the foregoing classes appeal to a physician, and a thorough examination, diagnosis and relief are not rendered. Thus many men to brace themselves up in order to do their day's work begin stimulating with liquor, which soon becomes a habit.

It is wiser to improve his circulation with medicine and prevent his creating a habit. I have seen many men with elimination fully re-established and circulation improved by medicine, drop the drink habit.

If the medical practitioners who complain of hard times

since sanitation is recognized as a necessity and practiced—and look longingly at the specialties, would treat their cases that come under their care, we would hear none of this.

We frequently hear the remark, that “He is a good doctor when you are very sick in bed, but does not pay attention when you are on your feet.” The office or walking patient is the hardest to obtain results from, whereas the bed patient is at rest and your treatment is bound to be more efficacious.

Educate your patients to continue treatment until a cure is effected, instead of only relief. The class that only continues medicine until relief is given, becomes rounders, going from one form of treatment to another, ranging from quackery to Christian Science. Others seek the seashore and in cold weather the warm climate where the natural conditions of the atmosphere aid elimination. This feature is what has made such fortunes in seashore and southern property.

#### CHART A.

##### DAILY REPORT OF WATER INGESTED AND URINE EXCRETED

		Water.		Urine.	
		quarts	I pint	quarts	
February	27th.....	4		4	
“	28th.....	3		3	I pint.
“	29th.....	4		3	I pint.
March	1st.....	4	I pint	2	I pint.
“	2nd.....	3		3	
“	3rd.....	3		3	
“	4th.....	3		3	
“	5th.....	2	I pint	4	
“	6th.....	4		3	
“	7th.....	3		3	
“	8th.....	3		3	I pint.
“	9th.....	3		3	
“	10th.....	3		3	
“	11th.....	3		3	

I want to show you one chart kept by a farmer who lived near my country home and consulted me. (See Chart A.) His was a case of Bright's, with so much rheumatism and such a weak heart that he sold his place because he could not take care of it. For several years I had known him to be an invalid.

After keeping the chart for one month, taking the indicated remedy and dieting, he procured a position at the most unsuitable occupation for him, delivering coal and feed. He has not lost a day's work. He continued treatment by mail and kept up the charts for thirteen months, his wife informing me and

sending for the medicine. He overdid the water drinking a little at first, but he was a very large raw-boned man. He was cured.

If a man of his class and occupation could be this accurate, it seems practical that any one in any class can keep the urine chart once a week and the "water drinking" chart daily.

I would like to cite two cases in particular.

A case of appendicitis—four days after I operated upon her, the menses appeared. She developed Temp. 103, pulse 110, respiration 28, nausea, vomiting, pain in abdomen, diarrhoea condition appeared alarming. Ipecac 3x given frequently reduced temperature to normal in six hours.

A case of appendicitis: A man of forty-five years, alcoholic, developed violent angina pectoris. His screams disturbed other patients. Became quiet from kali carb. 3x given frequently, and was able to go home in seven days. Favorite remedies with me are: Arnica 3x, puls. 3x, lycop. 6x, borax 3x, acon. 3x, belladonna 3x, staphisagria 3x, rhus. 3x.

In closing, wish to emphasize that diet, systematic elimination and the use of indicated remedy make surgery a beautiful success.

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### DRAINAGE.

BY

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(Read before the New Jersey State Homoeopathic Society, May 8, 1912.)

TEN years ago, when I had the pleasure of reading a paper before this honored Society, I touched on a subject that I wish to be pardoned for if I make a few further comments upon it, and that is "Drainage." This, to the surgeon, is of the utmost importance in dealing with infected wounds and abscessed conditions of the human body.

There are a few simple experiments to which I wish to call your attention. In going over physics in natural philosophy, the explanation that a syphon was worked by air pressure did not sound altogether right to me. Now, to show that a syphon will work without atmospheric pressure I will insert a piece of moist gauze in a vessel of water and leave one end hanging



over the outside of the glass, below the level of the fluid inside. Immediately there appears a drop of water: this continues, drop by drop until all is withdrawn from the vessel. You say this is capillarity, which I do not deny in part, but why does it continue to drop? Now, if I re-adjust the gauze until the inside liquid and the outside end of gauze are on a level the water will cease to drop, and if the outside end of gauze is elevated just a little higher than the level of the liquid inside, the pendent drop hanging on the outside end of the gauze will be drawn up into the gauze and back into the vessel. Therefore, it is the heavy weight on the long arm of the gauze on the inside that draws the pendent drop up and back into the vessel when the outside gauze is elevated above the inside liquid, thus showing a perfectly acting syphon and, a syphon that is in no way controlled by atmospheric pressure as the physicists tell us.

I recently read an article along these lines wherein the author emphatically stated that capillarity did not raise the water over an inch into the gauze above the water in which it was suspended. This is untrue. He also stated that a towel hung up by one end and the other end dipped into the water would not raise the water over one inch into the meshes of the towel. This is also untrue; debarring atmospheric evaporation, the towel will become moist all over. In a very dry, hot atmosphere, evaporation takes place so fast in the upper end of the towel that moisture can hardly be felt, but if this were kept under a bell-jar it would soon become moist all over. There are certain limits to this open form of syphon. The first is that if the strands of gauze are only inserted, one or two together, and one end is inserted into the water and the other allowed to hang over the outside of the vessel they will not start to drop from the end. The reason being, not that capillarity does not work, but that evaporation takes place faster along the course of the fibre than the water is sucked up by the thin strand of gauze. Now, on the other hand, if we enclose this thin strand of gauze within a small calibre rubber tube and insert one end into the water, in a short time it will begin dropping minute drops. Again by placing a ribbon of gauze, say one inch wide and eight inches long, one end of which is placed in water of the vessel and the other outside; you will find that the gauze soon becomes moist all over but will not drop from the outer end even though it be below the surface of the water in the glass some distance. In this case we have the same capillarity,

the same syphonic conditions, but the area exposed to the air surface is enough exposed to the air to cause evaporation as fast as capillarity sucks it up into its meshes and does not allow enough of water to get into the outside end of the syphon to overbalance the weight of the inside arm and thus we have no action. Take the same piece of gauze, twist it up like a rope and insert one end in the water same as before, leaving one end hanging over the outside below the water level and it will soon begin to drop. A twist of cotton will act in the same way but not so well unless it is twisted up pretty tight.

I omitted to say that the proof outside of that advanced here to prove a syphon does not act by air pressure is, to place a syphon inside a bell-jar and exhaust the air from it. The syphonic condition proceeds just the same in a tube or in a gauze drain placed as you see it here. This, I think, proves that air pressure has nothing to do with the actuation of a syphon.

What has all this to do with drainage and especially in surgery? Upon the application of these principles depend the successful draining of a cavity containing pus or pussy fluid. For instance, the draining of the abdominal cavity, bladder, pleural cavity, sinuses, etc. Where there is a concavity or hollow that will accumulate liquid, the application of the above principles can be applied with the utmost satisfaction. For instance, in suprapubic cystotomy, the entire bladder contents can be syphoned out by this method, and the wound and abdominal dressings be kept comparatively dry. In order to accomplish this, however, it is necessary to have a large calibre rubber tube with a piece of gauze drawn through it, the gauze emerging from each end plentifully. One end is introduced into the bladder and the other outside of the bed so that the outer end will be dependent about one foot below the bed. This to act as the long arm of the syphon. Another method of accomplishing the same end is to take a piece of oiled silk and roll up in it a twisted piece of gauze, leaving, of course, an excess of gauze at each end. This tied around with a little thread will answer just as well as a rubber tube syphon. This prevents evaporation into the atmosphere. This really is superior to a rubber tube as you can control the density of the gauze within the oiled silk as, if it be too tightly packed it might clog up sooner with pus cells and mucous or other debris, and this, by the way, is the only objection to this form of syphon or drain.

Plain gauze drains in draining the abdominal cavity or other places can be operated successfully by placing the gauze without covering down into the wound in the usual manner and cover the gauze with an outside sheet of oiled silk or rubber sheeting to prevent evaporation if desired. Rubber tubes, metal syphons and the like have long been known to be of better value to drain cavities such as I have mentioned, but, the gauze drain protected from evaporation and placed in the manner mentioned before will work admirably in most instances.

#### SURGICAL JUDGMENT.

Have you ever stopped to think why some man in the field of surgery become great? Men, such as Kelly, Mayo, Murphy, Keen, DeCosta and many of the older men who have gone before. Why was not Dr. Brown or Dr. Somebody Else just as famous as a surgeon? Why were not Dr. Osler and many other clinicians just as famous as surgeons as they were in their own line? The reasons why may be answered variously, you say, but the real reason is, because the men who achieved greatness in surgery had a keen sense of surgical judgment and great technical ability. It is this keen sense of perception that enables a surgeon to know just when and what to do for the best of his patient. Upon this keen judgment is based the success or failure of a surgical procedure and all that goes to make for the benefit and hasty recovery of the patient.

In no instance in the practice of medicine is this judgment more important than in surgery. Many a "would be" surgeon has lost his case as well as his reputation in not judging or gauging his case correctly. This judgment with the successful surgeon is a sort of inherent knowledge that he gains by experience and that he cannot impart to others, which thus makes him head and shoulders above others.

In what way does a man achieve distinction from others in the great field? He does so in gauging or judging the proper time, the right procedure, the extent of such procedure, the strength of the patient, the length of time required and all that, so as to have the patient come out of the anæsthetic in good condition. This is where the surgeon, to my mind, makes the grandstand play and not in the manner in which he swings his scalpel or the quickness with which he con-



cludes an operation. To do a nice, clean, skillful operation and fail to ligate securely a bleeding point which may be somewhat inaccessible, may result in the death of the patient. Of course, a surgeon who knows his business will have little trouble with accidents as he knows how to avoid them, but, there are many controllable accidents among the smaller country and smaller town hospitals when operators are inexperienced. Often more serious trouble is encountered than was anticipated; then comes the call for keen, quick judgment on the part of the surgeon as to what is best to do. This was strikingly exemplified in one of the Mayo clinics I witnessed last year. When doing a resection of a portion of the descending colon for stricture causing constipation, as was previously diagnosed before the operation, the whole descending colon was found constricted and irregular with enteroliths embedded in its structure at various points. Dr. W. J. Mayo was only an instant in saying, "We will do an ilio-coecal implantation into the sigmoid," and thus cut out the whole of the large bowel from the alimentary canal. In other words, short circuit the colon. This undoubtedly gave liquid movements instead of constipated ones.

Again, expert judgment is often called for as to when is it best for a patient to be operated on. Frequently, I have seen more extensive operations done than was warranted and, some important structure cut or torn, which endangered the life or even caused the death of the patient. Such would be lack of good judgment or sense.

In many cases of suppurative appendicitis where large accumulations of pus have been found, bad judgment was used in an effort to get the appendix at the expense of breaking down the limiting, adhesive wall and, thereby, spreading pus into the peritoneal cavity. This should under no circumstance be done, especially when the adhesions are of recent origin. It should be drained and packed after thorough irrigation and the appendix removed at some subsequent operation.

Another instance of bad judgment is in not leaving the peritoneal cavity open when we are not sure of our asepsis. It is better to have a gauze drain than to run chances. It was just recently, during an operation for appendicitis, that the external tissue of the abdominal wall was found oedematous on incision. On entering the peritoneal cavity, a small, hemmed off abscess was encountered. It was opened and mopped out with

great care, appendix removed, and, upon closing up the wound, I suggested to the consulting surgeon that a gauze drain be inserted. He unhesitatingly stated it was quite unnecessary. Thinking that, perhaps, his experience was better than mine, I acquiesced, and sewed up the wound completely. The fourth day the wound broke open and I extracted nearly a teacup of pus. Previous temperature and suffering warned us of the result. All the stitches had to come out and the wound treated as an open wound. Then, again, we exhibit poor judgment in our after-treatment by letting our patients get up too soon and go home from the hospital. I have frequently heard of it in from ten to twelve days and even less. This practice is to be condemned. First, for the reason that should subsequent wound infection occur, you do not have the facilities at home for such redressings. Second, more proneness to adhesions around the wound, especially abdominal wounds. Third, from a medico-legal standpoint, should any harm occur, the surgeon makes himself directly liable.

Another source of trouble arises from allowing patients to turn frequently after coming out of the ether. It strains on the stitches, increases vomiting, causes ligatures to slip causing hemorrhage and increases the tendency to the formation of adhesions.

Great care should be exercised in sewing up the peritoneum. Often, if one is not careful, the needle will catch in a section of the omentum or gut and on drawing the suture tight, whatever has been caught is drawn up against the inside peritoneum, when at that point adhesions will occur and afterward cause much pain.

Successful surgery speaks for itself and it is the little points that require our attention and make for success or failure. There are many men who do not undertake surgical procedures who, nevertheless, are compelled to treat surgical cases. These should have special warning regarding the surgical ability the law requires. Great surgeons are truly then born and not made. It is this great inherent quality of judgment with a certain amount of mechanical ability that brings out the talent of a surgeon.

## A CASE OF HYDATID MOLES WITH PENETRATION OF THE UTERINE WALL.

BY

DOUGLAS CAULKINS, M. D.

ON January 21, 1907, Mr. H. came to see me for a prescription to relieve his wife who was suffering from uterine hemorrhage.

Mrs. H. was forty-five years of age and up to this time had not menstruated for two years. I prescribed sabina 1x and heard nothing more from the case for two months, when Mr. H. returned and stated that the prescription had been effective, but that the hemorrhage had returned. I sent the same prescription and there was no further report until a month later. This report was similar to the previous one, namely, that the medicine had relieved the hemorrhage but it had again returned. I again prescribed sabina and had no further word until May 8th, when a message came asking me to go and see the case, which I did on the following day. I found a desperate state of affairs: temperature 103, pulse 140, very weak and thready, and the uterine cavity full of a sloughing mass of hydatids. An anaesthetic was out of the question owing to the weak condition of the heart and the need for instant action imperative. Having used antiseptic precautions I introduced my hand into the uterine cavity, in doing which I had no trouble as there was considerable distention of the vagina, and proceeded to detach the hydatid tissue from the uterine wall. I had great difficulty in accomplishing this as the moles had, in every instance, penetrated the uterine tissue and I had to exercise great force in order to separate them. This I finally succeeded in doing, and after cautiously curetting with a dull curette, I ordered a carbolyzed douche and proceeded to take stock of the situation. The temperature had fallen slightly but the pulse was very bad. I left medicine to sustain the heart and to encourage uterine contraction, gave a very dubious prognosis and promised to return the following day. This patient lived seven miles in the country so that close attention was impossible. The next day I called and found a little improvement. Patient had slept well; there was no extensive hemorrhage; the foul odor which the previous day had been very marked, had somewhat



subsided and I felt a little encouraged. I visited my patient daily for a week and the improvement continued; pulse grew stronger and slower, temperature gradually declined, appetite and sleep satisfactory.

It was now arranged that I should discontinue my visits and that Mr. H. should report any unfavorable symptoms. During the month following I had a number of reports from my patient—all of them favorable—and I supposed the case progressing toward recovery. On June 10th, I received a call to go to see her and on my arrival found my patient with a thready pulse of 160, a Hippocratic countenance and every indication of approaching collapse. The abdomen, externally, showed considerable enlargement and, I ascertained by a digital examination, that the uterine cavity was filled with a densely packed mass of tissue. I could imagine but one explanation for this, viz.—that the hydatids had reformed. I hesitated about inserting my hand into the uterus as my patient was in a dangerously collapsed state, but reflected that she was entitled to the only chance which offered any relief. I stimulated her with alcohol and proceeded to investigate the uterine cavity. Inserting my hand I extracted some of the contents for examination and found it to consist of intestinal and omental tissue in a state of slough, which sloughing condition I presumed to have been caused by the hydatid invasion. In extracting this tissue for examination, it became separated from the mass above at one of the sloughing points, leaving in my hand a considerable portion of the intestine and omentum. My patient was now unconscious and died a few minutes later.

In a search through medical literature, I find very few cases recorded where the hydatid has penetrated through the uterine wall, and only three cases where the uterine wall has sloughed to the extent mentioned above.

These cases are cited in the American Text-Book of Obstetrics. I cannot understand how my patient could have escaped the cardinal dangers of hemorrhage and septicaemia, before the condition which I have described could have arrived.

I will briefly recapitulate by stating that five weeks intervened between my first and last visit and that for four weeks of this time the patient seemed to be doing well, and yet, during this period, the hydatids were steadily accomplishing their deadly purpose and the fatal termination was inevitably approaching.

## A LETTER FROM ENGLAND.

WARNINGS are being uttered in England, as well as in America, against the pill and potion self treatment of illness; no matter how trifling it may appear, no one save an observing physician can say of a surety *when* medicine is needed. And even when administered by a physician a physic is *never* a cure for a disease. The old "cleaning out" process by pills is falling into general disrepute. Disease originates in the organs or tissues or cells of the body; it works its evil there and oftentimes does so much ill before discovered that the efforts of the regular school of medicine to arrest it, even if sometimes successful, cannot repair the injury already done. The lesions remain after the cause is removed.

Medicine can never even approach being an exact science until it can remove the causes of disease instead of merely palliating the symptoms that accompany it. Acute diseases have a natural tendency toward recovery regardless of the treatment. Chronic diseases, on the contrary, have exactly the opposite tendency, except, I may add, when treated according to the medical law evolved by Doctor Samuel Hahnemann. In the hands of a skilful physician of any school there is no doubt but what individual lives are saved and much suffering alleviated. Death is at least postponed, and in the milder cases a shorter road back to health is almost always discovered. Tuberculosis is now known to be caused by a bacillus, but as thousands of investigators have shown there are many varieties of tuberculosis, and that what may prove an appropriate treatment in *one* case is absolutely disastrous or fatal in another: in other words some cases are amenable to treatment, others hopeless. Some are hopeless when first seen which presumably could have been cured by an earlier diagnosis. The vaccine or serum treatment of disease has seemingly only added to the perplexities that were unsurmountable before, and if we take the disease called cancer for instance, notwithstanding the vast amount of work and unceasing investigations carried on in every civilized country under the sun, the actual cause of cancer is apparently as far from being known to-day as it ever has been. What science seems to need more than anything else is some wonderful and as yet undiscovered new weapon of research. The present methods of investigation as looked upon

by myself, seem like searching for a black cat in a coal cellar on a dark night with no light, after the cat has escaped. As yet science does not know even the cause of measles, or scarlet fever, or with any positiveness of a cold in the head. And so far as regular medicine is concerned, these diseases simply have to be coddled and physicked along as they have done for a century. Typhoid is known to be due to a bacillus, but the bacillus is certainly under very poor control. Diabetes is still a mystery and is under even less control than gout and rheumatism, so far at least as the dominant school of medicine is concerned. Medicine stands as yet hardly on the threshold of fruitful research. On the contrary there are two diseases the causes of which are better understood, and the prevention of which can to a great extent be accomplished by a propaganda of education and municipal action. Gonorrhœa and syphilis, probably much more prevalent on this side of the water than in America, are the same fell destroyers and medical research is, I believe, beginning at least to think that these two diseases may be the starting point of all the rest. Some wise lady is reported as having said "the more I see of man the better I like dogs," and I could never say more truthfully than now, after forty years' practice and observation, the more I see of drugs and serum therapy, the better I like homœopathy.

J. ARTHUR BULLARD, M. D.

London, England.

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FATAL CASE FOLLOWING INJECTION OF "606."—Mr. H. Moore reported a case of early general paralysis of the insane treated by "606," with fatal result. The patient, aged 25, was given 0.5 gramme intravenously. A severe reaction followed, his temperature rising to 103° F. It was normal next morning, and he left the hospital on the fifth day. Wassermann's reaction, which had been negative before injection, was positive four days after. Six weeks later, his general condition being much improved, but Wassermann's reaction being still positive, he was again given 0.5 gramme. The reaction was very severe, his temperature rising to 105°, with much diarrhœa, vomiting, and general pain. The reflexes, which were all exaggerated before injection, disappeared. He was much better the following morning, but that afternoon he had a second rigor, with rise of temperature to 102°. His general condition became rapidly worse—he got ptosis of the left eyelid, bilateral paresis of the limbs, and difficulty of articulation, and died that night.—*Royal Acad. Med. Ireland Lancet.*



## EDITORIAL

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### THE RELATIVE HEALTHFULNESS OF RURAL AND URBAN COMMUNITIES.

DURING recent years a great deal of attention has been given by sociologists to the economic and industrial phases of rural life. Prominent politicians, as well as political economists, have strongly emphasized the importance of checking the tendency of the population to center in the large cities and have urged a return to rural life and rural occupations.

In considering this problem we should bear in mind the fact that the sanitary aspects of it deserve considerable attention. It is urged by many that the country offers advantages for physical development and for the maintenance of a high standard of health. This aspect of the question, however, cannot be decided by mere dogmatic statements, but a careful study should be made of the average period of life and the mortality rate in rural districts should be carefully compared with similar statistics gathered from urban communities.

The statistics published by the Census Bureau show that during the year 1909 the death rate per 1,000 population in cities was 15.9; in the rural districts, in the same registration area, the death rate was 13.4. This would indicate a lower mortality rate in the rural districts. It must be remembered, however, that a great number of persons who are seriously ill are removed from rural districts to the large city hospitals, and many of them die in these hospitals and thus go to increase the number of deaths reported in the cities, while they diminish the number reported from the country districts.

Further study of the census statistics give us some interesting facts regarding the types of diseases that are more common in rural and urban districts. On this phase of the subject we have the following data:

	Pneumonia.	Tuberculosis. All Forms.	Fever. Typhoid	Measles.	Scarlet Fever.
Cities .....	171.	179.4	22.4	13.4	14.2
Rural .....	109.6	127.5	23.3	11.6	8.2
	Pertussis.	Diphtheria.	Diarrheas and Enteritis. Under 2 Years.	Suicide	Accident and Homicide.
Cities .....	11.4	25.7	118.	17.9	89.7
Rural .....	11.9	15.9	77.3	12.4	88.3

It will be seen from this table that the death rate in cities is higher from pneumonia, tuberculosis, measles, scarlet fever, diphtheria, diarrheas, suicides and slightly higher from accidents and homicide. The rural death rate is higher from typhoid fever and pertussis. In the case of pneumonia and tuberculosis, the beneficial effects of an abundant supply of fresh air in preventing the onset of these diseases, is made evident and the comparative immunity to them in rural districts is, no doubt, traceable to this cause.

The higher percentage of deaths in cities from infectious diseases is, of course, due to the greater opportunities for contagion among persons living in crowded communities.

In the case of typhoid fever the higher rural death rate is undoubtedly traceable to the poor sanitary arrangements existing in the country districts and the inadequate measures that are taken to prevent contamination of the water supply. In the case of diarrheas and gastro-intestinal diseases of children, it will be seen that the mortality rate is very decidedly lower in the country districts. This is probably the result of two factors: First, the percentage of breast-fed infants is much higher in the rural than in the urban districts. Second, the opportunities for securing fresh milk and fresh air for children are much better. It would seem then, that in the case of children and of infants who exhibit a tendency to intestinal or to respiratory diseases, the country offers many advantages from a sanitary standpoint. In fact, the longer average period of life that exists in rural communities is, no doubt, largely due to the low death rate during infancy.

The child who is raised in the country is not only more likely to survive but is likely to develop into a much healthier adult than the child raised in the urban community. This fact should not be lost sight of by those who are seeking to encourage a return of our population to the rural districts and should prove a very important factor in aiding such a movement.

—G. H. W.

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#### **SOME COMMENTS ON THE PRESIDENTIAL ADDRESS DELIVERED BEFORE THE AMERICAN INSTITUTE OF HOMOEOPATHY.**

THE scholarly and thoughtful address delivered by Dr. Thomas H. Carmichael, President of the American Institute of Homœopathy, before the recent meeting of the Institute in Pittsburgh, should be carefully read and thoughtfully considered by every practitioner of medicine and especially by every homœopathic practitioner.

The subject of Dr. Carmichael's address was the very important one of "Medical Unity," and he is of the opinion that the homœopathic school is best fitted to act as the leader in the solution of this difficult problem.

To the scientific mind it is perfectly obvious that the division of the medical profession into various sects and schools is an indication of the immature development of medical knowledge, or an example of unparalleled narrowness and bigotry. When we come to consider these two alternatives we feel that the latter does not fully explain the various sects in medicine as we find them to-day. That there is illiberality and bigotry on the part of a certain number of physicians in every school, cannot be denied. We are all familiar with the type of physician of the dominant school who is accustomed to swallow at one dose the entire supply of medicine that the homœopathic practitioner has left, in order to demonstrate the supposed inertness of homœopathic remedies and to show his contempt for the doctor who prescribes them. So, too, we find in the ranks of the homœopathic school, men who do not hesitate to attribute all the unfavorable results that occur in cases under old school treatment, to the pernicious activity of the doctor and his harmful drugging.

However, the vast majority of legitimate physicians in all schools of medical practice, are sincerely seeking after the truth in medicine and would not permit their prejudices or



their inclinations to bar them from a recognition of the truth as applied to therapeutic art, when once that truth has been fully and scientifically demonstrated to them. We are compelled to conclude, therefore, that medical sectarianism is primarily due to the immature development of medical science, with the result that each sect or school, having recognized and developed a certain *part* of therapeutic art, dogmatically assumes that they have discovered the *whole truth* of scientific therapeutics and that all other therapeutic principles and measures are fallacious and harmful. This magnification of a part above the whole constitutes the essence of sectarianism and the various other evils that accompany it.

Dr. Carmichael insists that the remedy for this condition lies, not in the enactment of restrictive laws nor in the political combination of one school with another, but in a general recognition, on the part of physicians, of the fundamental fact that the whole truth is greater than any of its parts and that there is no antagonism between the various parts which, fitly joined together, go to make up a harmonious and symmetrical whole.

As far as we are aware, no attempt has ever been made to encourage or bring about the unification of the medical profession in accordance with this spirit of scientific liberality.

The dominant school of medicine claims to be unsectarian in its principles and methods and makes a pretense of fostering medical unity. Its methods of securing medical unity, however, seem to be chiefly those of persecution and ridicule. It insists that medical unity must be attained by physicians by abandoning all the therapeutic methods which they have found efficacious in their practice that are not in accord with the tenets of the dominant school, and subscribing only to those views and methods which it (the old school) endorses. At the same time its members refuse to investigate seriously any method of therapeutics that does not coincide with their previously conceived ideas as to what is correct and traditional, and, as a matter of fact, confine themselves to methods of practice that are far more narrow and restrictive than are those of the homœopathic practitioners of medicine.

Dr. Carmichael insists that the homœopathic school is the best fitted to take the lead in bringing about the true unification of the medical profession on the basis of liberality and scientific investigation for the purpose of determining the

whole truth of therapeutics. He insists that the homœopathic school is unsectarian in its aims and in its practice and that it requires a wider knowledge of the medical art as a prerequisite to its membership than does any other school of medicine. "It has never required that a candidate for admission to its societies should abandon, either in practice or in belief, any part of medical knowledge. It gives its members freedom to consult with physicians of all schools. A careful examination of this statement will reveal the fact that in its efforts to comprehend all the facts of medicine, it represents the true spirit of catholicity." There are few medical men who would be bold enough to gainsay these facts and we believe that Dr. Carmichael has clearly demonstrated that if medical unity is to become an established fact, that it must be worked out along the lines he has suggested.

It is recognized by every careful observer, that no one system of medical practice embraces all there is of value in the therapeutic art. Only the most fanatical would claim that the homœopathic principle embraces all that there is in therapeutics, and yet, the therapeutic developments of recent years would seem to show conclusively that it is the most widely applicable principle that exists to-day for prescribing drugs in the treatment of the sick.

The allopathic school has persistently refused to avail itself of but one phase of drug action in the treatment of disease and despite the stand taken by a few of its advanced members here and there, the vast majority of old school practitioners look down with undisguised contempt upon any method of therapy that is not in accord with their established ideas of drug treatment.

Surgery, psychotherapy, dietetics, hydrotherapy, electrotherapy and a large number of other therapeutic measures of ever increasing importance are the common property of all legitimate schools of medicine. The distinction between the two predominant schools is founded primarily upon a difference of opinion as to the most effective method of prescribing drug agents. As a matter of fact, all therapeutic measures not involving the use of drugs are used by physicians of both schools, and various opinions exist among individual physicians of both schools as to their proper place in therapeutics.

Those who desire to bring about a unity in the profession that will be at all enduring must do so, not by persecution and

by narrow restrictions, but by bringing together all of the various therapeutic measures that are of practical value in the treatment of disease and welding them into one complete and harmonious whole.

—G. H. W.

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#### THE OPSONIC INDEX AS A GUIDE TO THE THERAPEUTIC PROPERTIES OF DRUGS.

Two or three years have now elapsed since Wright announced the results of his experiments relating to the opsonic index of the blood and predicted that the favorable or unfavorable action of a drug in disease should be largely determined by its effect upon the opsonic index. "Scientific" practitioners of the old school very enthusiastically adopted Wright's methods, and numerous investigators proceeded to publish reports of investigations made as to the effect of various medicinal agents on the opsonic index and gloried in the fact that they had at last found an accurate and scientific method of demonstrating the medial value of their drugs. In fact, the method was widely accepted as one of great accuracy until, alas! certain pathologists connected with homœopathic institutions were able to demonstrate that homœopathic remedies exercised a similar favorable effect upon the opsonic index. This served to dampen the ardor of some of the earlier enthusiasts, and when the Osteopaths, the Electro-therapeutists and others proceeded to prove that their therapeutic measures had a similarly beneficial effect upon the opsonic index, there were many who began to feel that they were treasuring a gold brick.

Recently Streubel, of Dresden, has published a series of reports in which he claims to have proven that the salts of iodine and bromin lower the resistance of the blood to various pyogenic bacteria; arsenic, on the other hand he states, increases the resistance of the body to the same micro-organisms. "What is sauce for the goose is sauce for the gander," and we cannot understand why studies in the opsonic index should be considered of such specific value in indicating the therapeutic usefulness of physiological remedies while similar investigations are considered of no importance in proving the efficacy of homœopathic remedies.

G. H. W.



## GLEANINGS

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REPORT OF THE COMMITTEE ON HOSPITAL DISPENSARY ABUSE.—H. S. Anders as chairman makes the report to the Philadelphia County Medical Society. The investigation included a definition of hospital and dispensary abuse and a letter with queries to department heads in various hospital dispensaries. The following are the queries:

1. Was any effort made in your department to eliminate patients who were able to pay a physician?
2. Did you direct your assistant to inquire from patients as to their ability to pay for medical service?
3. If this question was answered affirmatively did you refer the patient to his physician, if not what did you do?
4. Would the dispensary abuse have been diminished if applicants had established their inability to pay for services in a medical registrar's office, as a preliminary?

In answer to the above questions, some replies were affirmative, some were negative, and others non-committal. The following recommendations were offered:

1. Every dispensary physician should sincerely and steadily strive to abolish dispensary abuse.
2. A social service department should be established in each dispensary to ascertain the ability of patients to pay for medical services and the cases should be followed up with thoroughness to obtain accuracy of information.

DIAGNOSTIC AIDS IN SURGERY OF THE RENAL PELVIS AND URETER WITH SPECIAL REFERENCE TO PYELOGRAPHY.—W. F. Braasch, Rochester, Minn., *The Lancet-Clinic*, May 18, 1912. Braasch discusses radiography, meatoscopy, ureteral catheterization and pyelography, and brings out a number of interesting points. With good technic and proper interpretation every renal stone should be shown in a radiograph. In the lower ureter, however, in 5 to 10 per cent. of the cases, the stone may be missed. If the X-ray plate shows a shadow along the urinary tract there must be some calcareous substance present to cause it, and it is here that the other diagnostic aids, especially cystoscopy, comes into play to help one correctly interpret the findings.

The cystoscopic picture of the ureteral meatus is of great assistance. The meatus appears edematous and irritated when a stone is lodged in the bladder section of the ureter. The stone itself may be seen. Cloudy urine, with a shadow in the radiograph on the same side frequently means a stone. With a stone low down in the ureter there is frequently a reflex anuria lasting 10 to 15 minutes, which may be misinterpreted. A ureteral

stone may cause very purulent urine when at operation the kidney shows very little if any disease of its tissue.

Ureteral catheterization is of value not only for separating urines, but for giving information as to the patency of the ureter. Stone in the ureter will obstruct the catheter in more than 75 per cent. of the cases. In over 50 per cent. of these the obstruction can be passed and a sense of grating obtained. Evidence of hydronephrosis may be obtained by noting the amount of urine obtained after passing an obstruction. By injecting fluid into the pelvis the capacity may be measured, and any pelvis which contains more than an ounce of fluid without causing pain may be considered a surgical hydronephrosis.

Braasch has used pyelography (the radiographing of the kidney after injecting the pelvis full of a collargol solution) at St. Mary's Hospital with markedly good results. It is of special value in cases where a ureteral obstruction will not permit the passage of a catheter, but will still allow the passage of fluid. It offers the only means of diagnosing a ureteral dilatation above an obstruction. It reveals the fact that dilatation of the pelvis is the usual accompaniment of its inflammation, and is also of value in demonstrating how much kidney tissue is still present. In the case of renal neoplasms, about two-thirds of the cases coming to operation have shown recognizable changes in the pelvis. Pyelography is of great use in demonstrating congenital anomalies of the kidney and ureters, such as horseshoe kidney, branching ureters, etc. In these cases it may be the sole means of diagnosing them. Pyelography at times may be painful, but the author has seen no cases in which any injury or harm has followed its use.

**DIAGNOSIS OF DUODENAL ULCER.**—As a general rule it may be stated, says Herschel, that the symptoms of duodenal ulcer are those which were formerly at first called acid dyspepsia and more recently hyperchlorhydria. The writer thinks, however, that we are not justified in the assertion recently made by Moynihan, of Leeds, in a monograph upon duodenal ulcer that "*persistent hyperchlorhydria*. . . . is the medical term for the surgical condition duodenal ulcer." We undoubtedly find symptoms, which in practice cannot be distinguished from those of duodenal ulcer, in chronic gall-stone disease, and in chronic appendicitis; and there are most certainly both a condition of hyperchlorhydria due to proliferative gastritis and also one which is purely nervous condition. Nevertheless, the fact remains, and this is as far as the writer thinks we are justified in going, that there is a group of different affections comprising those enumerated above which are characterized by the symptom-complex to which stomach specialists for the last ten years have given the name of hyperchlorhydria, and that of these duodenal ulcer is by far the commonest."—*Interstate Med. Jour.*

**THE VACCINE THERAPY OF ACNE.**—Allen (*Journ. Vaccine Therap.*) says that before undertaking the treatment of any case it is essential that all predisposing causes be removed. Attention must be paid to the bowels, the diet of each patient regulated, "carious teeth must be stopped or extracted, crowns and bridges removed, and pyorrheic gums receive attention, while follicular tonsilitis should be adequately treated." Any

seborrhea of the scalp must be dealt with, and care be taken to keep the skin clean; the acne expressor may be required. The patient is then ready for vaccine treatment. Whenever possible, an autogenous vaccine should be secured, although good results have been obtained by using stock vaccines both of the acne bacillus and the staphylococcus albus. Begin with doses (five millions of the former, 100 millions of the latter) in combination. Injections are best given in the buttock, flank, or one and a half inches below the centre of the clavicle. In twenty-four to forty-eight hours there will be either definite improvement or a slight aggravation. Allen expresses his preference for such doses as will slightly aggravate the symptoms for forty-eight hours, followed by improvement lasting a week. Do not attempt to proceed too quickly. "In an average case the dose of 100 million staphylococcus and five million acne is repeated four or five times, at weekly intervals, and then increased to 250 millions and more; gradually increasing until a maximum of 2,000 million staphylococci and twenty million acne is reached." With the higher doses the injections must be less frequent. A severe case lasts six to twelve months.

**TREATMENT OF DIABETIC ACETONEMIA.**—Lepine (*The British Medical Journal*) refers to the difficulty of dealing with the carbohydrate supply in diabetes. If the carbohydrates are too restricted it has been found that there is a risk of aggravating the acetonemia, whilst if they are given too freely the diabetic condition becomes worse, and the glycolytic insufficiency increased. In each case daily analyses should be made to show how the acetonemia and glycosuria stand respectively. Sodium bicarbonate may be given in large doses to saturate the diacetic acid and oxybutyric acid in the blood; and to facilitate the elimination of the latter as a sodium salt. If acetonemia was simply an acidosis it would have been easy to deal with it in this way. But it is a special intoxication, and Desgrez having shown that the addition of alcohol to propionic and butyric acids diminishes their toxicity, the fact has been made use of with some favorable results in the treatment of acetonemia. Intravenous injections of alkalis are not on the whole to be recommended. If given at all they are best administered before coma has supervened. The solution the author uses is one of 17 grams of sodium bicarbonate to a litre of water—isonic. Two litres of this solution may be given, and an hour should be taken in its administration, so as not to overcharge the heart. Copious diuresis follows as a rule.

**IONISATION IN RINGWORM.**—Riddell (*Glasgow Med. Jour.*) condemns the use of X-rays in ringworm, as the alopecia which they produce is sometimes permanent. The Doctor recommends ionisation, using a solution of mercuric chloride (one per cent.) or of iodine (one per cent.) with potassium iodide. The hair is cut closely or shaved, the solution to be used is rubbed well into the part, and ten to fifteen folds of lint soaked in the solution are applied evenly to the surface, overlapping the diseased area. A suitable electrode, such as copper gauze, is carefully adapted to the surface of the lint so that at all points the contact may be equal. Electricity from the public supply, or from a battery of 20 or 30



cells, may be used. The other electrode is connected with a bath of water in which the arm or foot may be immersed. The current is turned on slowly and gradually increased so as not to cause discomfort to the patient. Sitzings should be of 40 to 50 minutes, and repeated twice or three times a week. Nine or ten sittings usually effect a cure. He regards the treatment as certain, and rapid, and safe.

IVY POISONING.—Dermatitis venenata, always very unpleasant and occasionally dangerous, presents as long a list of possible medicaments as is claimed for pertussis or pneumonia.

Recent studies have demonstrated the cause of the irritation and it is now known that the irritating agent may be neutralized by permanganate of potash solution. The application of the permanganate solution gives great relief and when used soon after exposure or as soon as the first vesicles appear will avert the distressing itching. Treatment should be as follows: First thoroughly wash the part or parts with warm water and soap; then use an alkaline wash, as for example a teaspoonful of bicarbonate of soda to one pint of water. Following this should come several washings in warm 2 per cent. to 4 per cent. solution of permanganate of potash. The strength of the permanganate solution should vary according to the severity of the attack.—*Med. Rev. of Reviews.*

SURGICAL ANESTHESIA.—R. H. Ferguson summarizes as follows the lessons to be learned from a study of the influence of alcohol, ether and chloroform upon the resisting power of the body to disease.

1. Alcohol must not be given in the infectious diseases, especially in pneumonia and sepsis.
2. For surgical anesthesia administer the smallest possible quantity of any anesthetic.
3. Alcohol must not be used as a stimulant during or after anesthesia if the opsonic power of the blood is of any importance.
4. The anesthesia should always be as short as possible.
5. Only ether or chloroform which is absolutely pure should be used.
6. Special precautions for asepsis and antisepsis must be taken in all operations which are of considerable duration. Slight infections may develop into serious conditions after anesthesia owing to impaired resistance.
7. Six ounces of olive oil should be injected high into the rectum in all septic cases and also in others in which resistance to infections will be required.
8. Time is important in restoring the opsonic index, hence the oil injection must not be forgotten.
9. The oil must be injected slowly lest it may not be retained.
10. Pure limpid olive oil must be used in order that it may be absorbed quickly.
11. When uncertain about the value of the injection of oil, always use it to be on the safe side.—*New York Med. Jour.*

VALUE OF THE WASSERMANN REACTION IN A GENERAL MEDICAL SERVICE.—Weill tested all the patients who entered his medical service during six months with the Wassermann reaction. None of these patients came in

on account of florid syphilis, and all syphilitic cases were supposed to have been sent to another clinic. The patients tested were 225 in number; of these 64 reacted positively to the Wassermann test, that is, 28.44 per cent. After the positive test they were carefully questioned as to their previous illnesses and in all cases they admitted having had syphilis. There were among these patients cases of visceral sclerosis, diabetes, bronchial dilatation, aortic dilatation, neoplasms, icterus, cerebral hemorrhage and softening, tabes, general paresis, amyotrophic lateral sclerosis, Jacksonian epilepsy, meningomyelitis, and other nervous phenomena. The author's results give a valuable demonstration of the value of the Wassermann reaction in general medicine. This reaction allows one to recognize many cases of syphilis that would not be otherwise detected, and to treat them properly. It shows the terribly disastrous effects of the disease and the profound mental and moral decay that it causes. Nearly all the nervous maladies of organic form seem to be due to syphilis.—*Journal Medical de Bruxelles*.

REMOVAL OF FEMALE BEARD.—Schwentler-Trachsler states that the methods for the removal of hair from the female face have serious disadvantages. Destruction of the papillæ by electrolysis requires considerable technical skill, is extremely tedious, and in unpracticed hands causes pain and deformity. Kromayer's plan of removing the papilla with the surrounding skin, by means of a very small, sharp cutaneous punch, is entirely too severe for use on any but a few isolated coarse hairs, which can better be handled by electrolysis. Epilation by X-ray has been abandoned even by the radio-therapeutists; the dangers of atrophy and ulceration are entirely too great. All other methods of abnormal hair removal are merely temporary and but little better than shaving. The author had noticed that hair growth, both lanugo and coarse, was markedly hindered by the vigorous employment of pumice stone when used in the treatment of acne and other conditions. Applying this to the treatment of hypertrichosis, she began several years ago to treat every case that presented itself with vigorous pumice stone frictions twice daily, after the coarser and more isolated hairs had been removed by electrolysis. She had treated 252 cases successfully by this combined method; all varieties of hirsuties were included, but the method is especially applicable to cases where an abundant lanugo growth partially or entirely precludes the use of other methods. The only contraindication that she has observed is the presence of an inflammatory reaction, in which case treatment must be stopped until that has disappeared. Schwentler-Trachsler has waited for years before publishing these results, in order to be satisfied of the permanency of the results attained.—*Medical Brief*.

DISCUSSION ON THE TREATMENT OF TUBERCULOUS JOINT DISEASES IN CHILDREN.—Tubby (*British Journal of Children's Diseases*) after reviewing the earlier methods of treatment said that three factors were responsible for the great changes which had occurred in practice (1) The effect of climatic and sanatorium treatment; (2) the valuable aids to the diagnosis given by the Roentgen rays, and (3) the use of the new forms of tuberculin. In any case, the duration of the disease must be reckoned in

years not in months. He felt that conservative measures gave better results, both as to the cure of the disease and retention of function, than the so-called radical operations. Sir Anthony Bowlby dealt with the results obtainable without operation. Children had capabilities of repair denied to adults, and the outlook as regards cure was very favorable under proper treatment. The important items in treatment were good food, including a liberal supply of milk, an open-air life, rest and plenty of attention to the general health and local disorders, such as adenoids and bad teeth. He thought he had seen tuberculin do good in some cases. His treatment of abscesses was aseptic incision and temporary drainage. Even when there were open and septic sinuses good results could be obtained by attending to the general health. He amputated less and less frequently for even apparently desperate conditions. Mr. Robert Jones said that tubercle in the early stage in children nearly always ran a benign course, providing three things were attended to: (1) That the affected part should have absolute rest, (2) that the child should have good food, (3) the child should have good country air, being out of doors day and night. Immobilization of the joint should be very complete. The Doctor's practice was never to open an abscess till it came up to the surface, and then only by a small puncture. Sir Watson Cheyne said that he now practically never operated on a tuberculous joint in a child. In the treatment of abscesses he used antiseptics and aseptics, opened freely, and scraped it out. The Doctor always used tuberculin, but had never seen a definite good result he could attribute to it.—*Charlotte Med. Jour.*

**SYPHILIS RELAPSES UNDER MERCURIAL AND SALVARSAN TREATMENT RESPECTIVELY.**—Harrison (*Journal of the Royal Army Medical Corps*) says that in untreated cases of syphilis and those under mercurial treatment, the character of the symptoms is generally in accordance with the time which has elapsed since the primary sore made its first appearance. The intervals between the successive stages may be lengthened by mercurial treatment, but, speaking generally, early symptoms are not repeated. Thus primary sores do not recur two months or longer after they have healed, nor do early secondary rashes return in any high proportion three months or longer after they have disappeared.

With salvarsan-treated cases, the experience has been different from this. Of the cases suffering from primary sore only, which were treated with salvarsan, active signs returned in five after intervals of two and a half to ten and a half months, and in four of these the only sign of the relapse was the chancre, which recurred two and a half, two and a half, ten and a half, and three and a half months respectively after first healing. Out of eleven cases which suffered from early secondary rash when they first came under treatment and subsequently relapsed, in eight the same rash returned, twelve, four, three, ten, seven, seven, four, and seven months respectively after it had first disappeared. One of these cases was instructive in this respect: he was first treated with salvarsan for roseola, sore throat, and synovitis, all of which rapidly disappeared after the injection. Subsequently he suffered from two relapses which occurred three and six months respectively after the first injection, and on each of these occasions all the above symptoms returned.



The sequence of events in syphilis, which has been roughly divided into primary, secondary, and tertiary syphilis, and parasyphilie, is capable of two explanations: (1) That the *spirochætæ pallida* undergoes a series of changes when resident in the tissues, and that in each of these successive phases the symptoms to which it can give rise are peculiar to the stage at which it has arrived. (2) That it is the tissues which change, so that the longer the *spirochætæ* acts on them, the more the lesions which result from any increased activity of this parasite approach, first, the characters peculiar to the so-called secondary, and then those of the tertiary stage.

The first explanation would be difficult to prove, and against it is the fact that infection with *spirochætæ* derived from a secondary or tertiary lesion results in a primary sore. In favor of the second explanation is the well-known fact that in the majority of cases of syphilis, whether untreated or treated with mercury, reinoculation does not result in the production of a second chancre. As Queryrat showed, this refractory behavior of the skin and mucous membranes to infection from without is gradually developed during the ten days which succeed the appearance of the primary sore; as the end of this period approaches the sore resulting from reinoculation becomes more and more evanescent till, finally, no chancre follows. Finger and Landsteiner succeeded in producing skin lesions in such cases by inserting large amounts of syphilitic virus in pockets under the epidermis; these were not chancres, however, but simulated the lesions from which the patient was suffering at the time. Thus in the secondary stage a papule followed the inoculation, while in patients suffering from gummata or ulcerating syphilides identical lesions formed at the sites of inoculation. That these were due to the newly introduced *spirochætæ*, and not to those already infecting the patients, was shown by the fact that if the former was previously killed the result of the inoculation was negative.

The evidence is, therefore, strongly in favor of the theory that it is the length of time during which the *spirochætæ* have acted on the tissues which determines the characters of the successive manifestations of syphilis.

If we accept this view, the nature of the above-mentioned relapses in cases treated with salvarsan only indicates that from the date of the last injection till shortly before the appearance of the clinical symptoms the *spirochætæ* had not been active in the majority of cases. This is supported by the fact that in most of these the Wassermann reaction had returned to positive only three or four weeks before clinical symptoms returned, and it shows that, unlike the case with the great majority of patients who are treated with mercury, the latency was not apparent only, but real. It remains to be seen whether cases which relapse clinically many months after the Wassermann reaction has returned to positive will have symptoms of a later type than those for which they were first treated; since the Wassermann reaction, as ordinarily elicited, is not an index of immunity, but closely accords with the activity of the parasites, it is to be expected that they will.

Further evidence of the superiority of salvarsan over mercury in its action on the *S. pallida* is afforded by the cases of reinfection which have

been recorded; one undoubted case of this kind has occurred.—*Charlotte Med. Jour.*

ENEMATA AND THE MURPHY DRIP. Martin, in referring to the value and uses of the gradual administration of water by the rectum, quotes from a letter of Murphy's as follows:

1. That the natural condition of the large intestine is one of distention.
2. That the large intestine is a "dryer" of the alimentary material.
3. That all of the feces passes into the large intestine in a fluid or semi-fluid state and is dried—that is, the fluid is extracted in the large intestine.

4. That the material in the large intestine is always held under low pressure or tension; when gas is formed or comes into the large intestine, producing a higher tension, it is immediately expelled.

5. On this basis it has been learned that bland, isotonic fluids are rapidly absorbed by the large intestine.

6. If the tension is increased beyond a four or seven-inch hydraulic pressure, it causes a spasm of the bowel and discomfort relieved only by expulsion of the material.

7. It does not matter how fast the fluid is permitted to flow in. If the plus pressure is only four inches hydraulic, it will not be expelled by the intestine. Furthermore, it will not flow in rapidly with that pressure, as this is just about the intra-abdominal tension.

8. Normal salt solution, plain or with a teaspoonful of powdered corn-starch added, can be admitted and will be absorbed in quantities ranging from sixteen to thirty pints in twenty-four hours if the plus pressure does not exceed four inches under normal physiologic conditions, or an inch or two more in inflammatory conditions, which cause the abdominal tension to be increased.

9. It can, therefore, be readily seen that salt solution admitted by the drop or any other method into the bowel, accumulating there attains a pressure equal to the hydraulic pressure in the bag or can. And if the can is elevated more than six or seven inches above the level of the buttock or rectum, the pressure will become too great in the bowel—quickly if there is no clamp or restriction on the tube; slowly if the tube is restricted to a drop condition—but eventually in both so as to cause expulsion of the fluid.

10. If gas is formed in the large intestine when water is being admitted, the bowel will endeavor to expel it; and unless the tube is large and a means of rapid escape provided for, the gas with the fluid will be expelled.

11. A large tube, of three-eighths to one-half inch in diameter, is, therefore, essential to the proper administration of rectal salines. With no restriction or clamp on the outlet arm of the tube, the rapid expulsion can take place back into the can if the latter be low.

12. Any type of can or bag syringe can be fitted so as to have the material admitted drop by drop, and yet have a provision for its free return into the reservoir, with or without gas, should the tension on the intestine become too great or should the patient strain. From the reservoir leads a tube provided with a cut-off and a glass syringe from which the piston

has been removed and a pipette substituted. This is connected with one arm of a Y-tube, the other arm having the escape tube leading to the top of the reservoir, while the main arm is in connection with the rectal tube.

13. Four ounces or eight ounces given in twenty-four hours would be very much like putting on a postage stamp where a Mason-apron size poultice is needed. It is inefficient, unscientific, and a delusion to the doctor and to the patient.

14. The portion of the tube within the rectum may be of soft or of hard rubber or of glass. If the last two, it should be so fixed that the outer end will not compress against the mattress and cause counter-pressure by the inner end upon the rectum. The tube should have good-sized openings. If multiple, they should be one-eighth inch in diameter; if single, a third of an inch, so that particles of feces and the fluid may return to the can when the pressure exceeds the desirable tension.

15. Various devices have been resorted to in order to keep the fluid warm. Thus, there may be employed a tin can covered with asbestos, perforated to allow the passage of the inlet tube, and filled with water. If the water in the can be heated to 105 degrees F. at the beginning of the process, and the can wrapped in a Turkish towel, or its equivalent, the heat will be retained, provided the tube is kept covered with bed-clothing.

16. A pint and a half of normal saline solution is given every two hours, and the can is so elevated that about an hour or an hour and a quarter is required for that quantity to flow in if arranged for the drop-method. This means about forty-five drops in fifteen seconds.—*New Orleans Medical and Surgical Journal*.

THE X-RAYS AS AN AID IN MAKING DIAGNOSIS OF CONDITIONS IN THE RECTUM AND OTHER PORTIONS OF THE LARGE INTESTINES.—J. R. Pennington, of Chicago, stated that while the rectum is easily inspected by various specula, and the sigmoid is less readily accessible by the use of sigmoidoscopes, such as the one with insufflation devised by him, the colon is inaccessible and its exact position difficult to ascertain. Very often it is also difficult to determine and locate pathologic conditions in the large intestines.

Until recently the means of diagnosis have been limited to those used in other portions of the alimentary canal, viz.: Inspection after dilatation of the bowel with air or water, palpation, percussion, and trans-illumination. All of these are open to the objection that they are uncertain.

The writer observed in the latter part of 1899 that by introducing some agent into the large bowel which would cast a shadow, the X-rays may become useful in making a diagnosis of conditions in the twin cavities. It is only recently, however, that such procedures have become of practical value.

A bismuth meal is useful in diseases of the stomach or duodenum, the agent being suspended in milk, acacia water, thick soup or some similar vehicle.

But for the large bowel, the action of bismuth per os is very slow. One author estimates that it requires from twelve to fifteen hours for bismuth mixture to reach the ileo-cecal valve; about twenty-four hours to gain the



transverse colon, and thirty-six hours to penetrate to the sigmoid. By the method advocated this is done, so to speak, instantaneously.

Coming now to the technic: The patient's bowels are first cleansed by means of laxatives and injections. He is then placed in the knee-shoulder position, and from twenty-five to thirty ounces of the mixture used for casting the shadow injected into the large intestine. For this purpose the author uses an ordinary irrigator and a short rectal tip. A long rectal or colonic tube for administering the injection is unnecessary. After the suspension is injected the patient lies on his right side for a few moments so part of menstruum may pass into the cecum. He is then placed in either dorsal or ventral position on the radiographic table and the picture taken.—*Medical Brief.*

FLATULENCY AND ITS TREATMENT.—No satisfactory results can be expected in the treatment of flatulency unless its etiologic factors are appreciated before medication is begun.

Excessive collections of gases may take place either in the stomach, the small intestine or in the large intestine. When the flatulence is of gastric origin, the source of the gas, according to Boas's classification, may be exogenous or endogenous; exogenous, when air is taken into the stomach while eating in quantities greater than normal, or between meals by hysterical "cribbers." Endogenous flatulency occurs in the stomach, when digestion is slow or imperfect, resulting in the formation of gases together with the production of butyric, lactic, or acetic acids.

Flatulency having its origin in the intestines, is usually endogenous. Very little of the air swallowed during eating passes through the pylorus. Excessive collections of gases in the intestines may be due to various causes, of which the improper digestion of food is the most important. Next of importance is the type of flatulency due to lessened expulsion of gases formed as a result of a general atony of the intestinal musculature; or as the result of mechanical obstruction by adhesions, kinks or visceroposes. This type of flatulency is usually associated with obstinate constipation and colicky pains. A third, but no less important type of flatulency, is due to the lessened absorption of gases, resulting from venous obstruction in the intestines. This type is present usually in cardiac and hepatic disease, though often overlooked.

Bearing these etiological factors in mind, an intelligent treatment of the condition can be commenced. The exogenous type of gastric flatulency is usually associated with frequent belching of enormous quantities of inodorous gases and occurs mostly in hysterical individuals. The treatment, obviously, must be directed towards the hysterical features of the case. Such patients are benefited by directing their attention away from themselves; outdoor exercise, cold sponges, and similar procedures. Medically, nothing is so satisfactory in such cases as the use of frequently repeated moderate sized doses of asafœtida.

In treating the endogenous type of gastric flatulency, diet is of the first importance. The tolerance which the patient fears for certain foodstuffs must first carefully be studied, all fermentable foods must be prohibited. As a rule, milk, buttermilk, cheese, eggs, rare meats, fresh bread and cakes, are poorly borne by such patients. Vegetables rich in cellulose, such

as cabbage, beans and tomatoes, are likewise poorly borne. All food must be eaten slowly and thoroughly masticated. It is best to avoid all carbonated drinks; soups and tea should be forbidden. Flatulency associated with gastric atony is benefited greatly by the administration of tincture of *nux vomica* in 10 minim doses after meals, with or without a mild purgative, of which the tincture of rhubarb (aqueous) is probably the best. When the eructations are odorous, drop doses of phenol are of service; or dilute hydrochloric acid, 10 drops to a half glass of water, taken with the meals, is of benefit when the eructations are not sour. Flatulency associated with acid eructations responds best to a combination of bismuth, animal charcoal and sodium bicarbonate; if constipation is present, calcined magnesia may be substituted for the bismuth. Resorcin is also of service.

In patients suffering from the intestinal type of flatulency, diet again is of the first importance. Such patients, as a rule, do well on thoroughly cooked farinaceous foods. All green vegetables, if they are well cooked and macerated, are satisfactorily borne, excepting those which belong to the cabbage family. Vegetables which contain much cellulose and sulphur cause distress because of the sulphuretted hydrogen which is formed in the intestines. Eggs, rare meats and bananas give rise to large amounts of gas in the intestines.

Of the drugs which may be used as palliatives in intestinal flatulency, salol and magnesium salicylate are most valuable given in 10-15 grain doses after meals, alone or in combination with a purgative, of which compound rhubarb powder is probably the best.

Flatulency associated with constipation is best treated by directing the attention to the constipation. A daily saline enema is usually sufficient to rid the patient of his annoying distention and colic. A systematic massage of the abdominal walls several times a day will aid greatly in overcoming the atonic condition of the intestinal walls.

Finally, before being satisfied that everything has been done to relieve the patient of his flatulency, be sure that a careful examination of the circulatory system has been made; for it is only by improving the venous circulation in the intestines, that obstinate cases of flatulency can be overcome.—*Med. Review of Reviews*.

THE DIAGNOSIS OF ATYPICAL SCARLET FEVER.—By Dr. J. D. M. Miller (*Arch. of Ped.*) The author sums up his paper in the following manner:

1. The differentiation of unusual forms of scarlet fever will remain a stumbling block to the practitioner, until we have discovered the cause of the disease, and are able to employ similar tests to those that we now apply to diphtheria, typhoid fever, syphilis, etc.

2. Not one of the individual symptoms can be depended upon to establish the diagnosis. The disease may occur without rash, desquamation, fever or strawberry tongue. The whole clinical picture must be carefully considered and the individual symptoms critically studied.

3. The most constant symptom is the angina; and its presence, associated with scarlatinal eruption, however slight, however evanescent and however limited in its distribution, should be regarded as sufficient to es-

tablish the diagnosis—or, at least, to demand isolation and close observation.

4. Next to the throat the condition of the tongue is the most reliable symptom, some enlargement of the papillæ of the tip and border being usually observable, although this symptom is much more frequently missing than is the angina, and may occur in other conditions.

5. Of all the exanthemata, scarlet fever is the most varied and uncertain in its symptoms; and of all of the symptoms, the rash presents the greatest vagaries. Hence, no rash, especially in a child, is too trivial to be disregarded, whatever the general symptoms may be.

6. Scarlet fever with well-marked rash may occur without desquamation.

7. Rubella scarlatinosa is often diagnosed when scarlet fever presents itself as a pronounced erythema with mild constitutional symptoms. This error is a fruitful source of dissemination of the more serious affection. The diagnosis of rubella should be accepted only upon the strongest evidence.

8. The history of a previous attack of scarlet fever should not prevent us from treating with suspicion apparently anomalous cases of the disease.

9. Differential blood-counts have produced nothing of value in the diagnosis of scarlet fever.

10. Surgical scarlet fever and scarlet fever following burns are scarlet fever in the wounded, and should be treated and regarded as ordinary cases of the disease.

11. Scarlet fever without eruption, and other anomalous forms of scarlet fever, are a fruitful source of dissemination of the disease.

12. Finally, all doubtful erythemata, and all cases in any way resembling scarlet fever, should be quarantined until the diagnosis is reasonably established.

CLIMACTERIC DISTURBANCES IN WOMEN.—By Dr. P. Jung (*Deutsche Medizinische Wochenschrift*, April 4, 1912).

The author comments on the lack of causal treatment for these disturbances, but adds that much can be done by hygiene and dieting. The directions for a suitable diet must be explicit, as general directions are usually disregarded. As the disturbances are principally of vasomotor origin, the patients must avoid everything that tends to raise the blood pressure, especially alcohol and coffee. Lemonade, mineral water or milk should be the beverages, with possibly weak tea or cocoa. All highly seasoned, salted or peppery articles of food should be avoided. Lemon juice should be used in place of vinegar in salads. Meat should be eaten sparingly, eggs and vegetables being given the preference. No purgatives should be allowed but the bowels kept regular with a diet rich in waste material, and one or two hours in the open air every day. Hydrotherapy is very useful for its sedative effects. A moist pack for two hours in the evening will insure a good sleep, or a bath before retiring. Cold rubs in the morning, returning to bed for an hour or so afterwards are useful. Narcotics should be avoided, as they lead so easily to addiction; if drugs are necessary some harmless one like valerian should be used. No certain benefit, he remarks can be realized from commercial ovarian extracts except by the



manufacturers. Their action on the patient is very uncertain, but they can be tried. If no benefit follows the taking of a hundred tablets better drop this method of treatment. The tendency to obesity can be combatted by restricting the number of calories in the food and by diligent out-door exercise. Thyroid extract should be tried only under constant medical supervision, and it should be abandoned at the slightest signs of injury of the heart. He emphasizes the indispensable necessity of curetting the uterus in case of uterine hemorrhage. This is the only means to exclude cancer of the body of the uterus. If the hemorrhage recurs later medical measures should be tried. If all these fail, then the uterus will have to be removed unless roentgeno-therapy is given a trial. Cystitis is exceptionally common at the menopause, and usually yields to the general measures for its relief.—*The Post-Graduate*.

THROMBO-ANGIITIS OBLITERANS: A CLINICAL AND PATHOLOGICAL STUDY.  
—By Drs. T. Homer Coffen and Charles Gordon Heyd (*American Journal of the Medical Sciences*, March, 1912).

Of the ill-defined group of so-called vasomotor tropho-neuroses, one type stands out as having a distinct symptom complex and definite pathological findings. This has been variously described, but Buerger in 1908 defined the condition of presenile spontaneous gangrene as thrombo-angiitis obliterans. This type occurs in non luetic young men with a low blood pressure and before the arteriosclerotic age. The symptoms are fairly constant and embrace indefinite pains and hyperesthesias in calf, foot and toes, numbness and coldness in unfavorable weather; together with attacks which closely simulate intermittent claudication; characterized objectively by erythromelia, ischemia in the elevated position, pulseless vessels and trophic changes usually terminating in gangrene. The pathological interpretation has varied from a presumed angiospasm up to an actual organic arterial change. Winiwarter in 1897 claimed that the process was an obliterating endarteritis. Buerger in 1908 advanced the theory that the condition was a primary thrombosis with obliteration of the arterial lumen and that what appears as an intimal change is in reality a process of vascularization at the periphery of a primary thrombotic mass.

The authors from the study of a typical case found the following conditions: Histological study of the nerves and muscle from the affected area showed a neuritis and atrophy respectively. Careful study of specially prepared sections showed occasional proliferation of the elastic tissue lamina, characteristic of arteriosclerosis. There were no plaques or crescentic lamellæ decreasing the caliber of the arteries, such as are found in well-marked cases of angiosclerosis. There was clearly demonstrated a proliferative process in the intima and to a slight extent in the subintimal tissue leading to a considerable increase in the endothelial cells which encroached upon and became part of the organization at the periphery of the thrombus. In addition there was a partial reduplication of the intimal connective tissue membrane which strongly suggested a pure arteriosclerosis. Buerger contends that such newly-formed tissue is purely secondary to the primary thrombus.

They conclude: (1) There is no definite proof to support the theory of a definite and distinct angiospasm as the causal factor. (2) The known

pathological anatomy seems to prove an organic endothelial change as the active agent, leading to thrombosis and organization within the arterial lumen. (3) Thrombo-angiitis obliterans (Buerger) is a clinical entity of unknown etiology with a distinct symptomatology but at present doubtful pathological explanation.—*Post-Graduate.*

**SARCOMA OF ORBIT.**—The patient, a colored woman, had first been seen in October, 1910, when she stated that her right eyelids had begun to swell four months previously. There had been a very extensive swelling in front of the right ear. The patient had also had a number of pronounced syphilitic lesions, for which she had been treated. The right eye then protruded 4 to 5 mm., and through the thickened upper lid an edge of firm tissue could be felt under the upper orbital margin. Except that the veins were double the normal size, the fundus was normal. There was tenderness over the lacrimal gland. The patient was not seen from October, 1910, to February 5, 1912, when she returned for operation. The eye protruded about 30 mm., and was blind. Two days later the eye was removed, when the orbit was found filled with a firm immovable tumor mass. Exenteration of the orbit was then done, the periosteum stripping freely to near the apex of the orbit, which seemed free from tumor. The conjunctiva and other tissues were removed from the skin of the lids, and the lid margins cut off, including the roots of the lashes. The skin of the lids was pushed against the orbital walls. There had been steady granulation of the bone surface, with the exception of a small area over the os planum.—*Dr. Edward Jackson. Colorado Ophthalmological Society.*

WILLIAM SPENCER, M. D.

**FULMINATING ALBUMINURIC RETINITIS.**—The author reported a case of rapidly fatal nephritis in which examination of the eyegrounds had given the first indication of the presence of the disease. On November 9, 1911, the patient, a man of 29 years, came for ophthalmologic examination on account of pains over the eye and misty vision which had lasted for a week, and also slight transient conjunctivae redness. Correcting lenses gave vision 5-3, with accommodation 6.50 in each eye. The ophthalmoscope revealed a patch of retinal edema below and to the temporal side of the left macula; and smaller spots of edema peripherally. The patient was referred to his general physician, who made a diagnosis of chronic interstitial nephritis. The blood pressure was between 180 and 220 m.m., Hg. Early in December the general condition grew worse, and the areas of exudate were more marked. On the 18th of December there were small retinal hemorrhages, and left papilledema, and vision was O. D., 5-5 +; O. S. 5-9 +. The patient died suddenly a few weeks later on his way to the Riviera, the press dispatch stating that at the time of his death he had become totally blind.—*Dr. G. F. Libby. Annals of Ophthalmol.*

WILLIAM SPENCER, M. D.

## Monthly Retrospect

### OF HOMOEOPATHIC MATERIA MEDICA AND THERAPEUTICS

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CONDUCTED BY A. LEIGHT MONROE,

Miami, Florida.

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**THE TREATMENT OF HAY FEVER.**—The underlying neurosis should receive our first attention, and the strictest possible attention should be given to care of diet, clothing, and general hygiene. The food should be of such a character as to cause as little retention of waste products as possible, and a considerable amount of pure water should be insisted upon, apart from the regular meals. The skin should be kept active by proper bathing, and the use of cold sponge or shower, followed by a vigorous rub-down. Cold applications are only of value when followed by a prompt and lasting reaction. The method of using cold applications should then vary with the reactionary power of the patient.

Massage, spinal vibration, and the high frequency current are of undoubted value, particularly the latter. We know that under the high frequency treatment elimination of CO<sub>2</sub> is increased, that the blood is more perfectly oxygenated, and that the relations of uric acid and urea are reduced to normal; and that there is an increase in the production of heat, the body temperature remaining normal. Personally, I have the greatest confidence in the helpfulness of this method of treatment. I use not only the monopole, but also the vacuum electrodes over the nasal passages, spine and chest, with, I am sure, beneficial results. If possible an unfavorable environment or occupation should be changed.

#### TREATMENT OF THE LOCAL CONDITION.

It is hardly necessary to say that during the intervals of comparative freedom from irritation the intra-nasal structures should be carefully examined by the aid of a good light, a proper speculum, probe and some depleting solution, such as cocaine, or suprarenal solution. The latter should not be used until as much information has been obtained as possible from a gross inspection. All abnormalities found should be corrected. After a period of some weeks following surgical procedures the nose should be tested with a probe for hyperesthetic areas, and these cauterized superficially with the galvano cautery or glacial acetic acid. Usually two or three areas can be obtunded at a sitting.

Local treatment should be strictly individualized. Rarely will the patient tolerate any but the mildest and most soothing applications. Occasionally a simple alkaline solution used in a nasal douche for cleansing pur-



poses will give a certain amount of relief, but even that should be cautiously used, and withheld if irritation is the sequence.

One of the suprarenal preparations, diluted with two parts water, may in some individuals bring about much relief if used locally and internally. One author says, "The specialist by these means (hygiene and suprarenal solution) should be able to relieve all of his hay fever patients, and cure seventy-five per cent." Time and experience have not by any means substantiated this contention.

There is no doubt of the value of Dunbar's "Pollantin" in a small percentage of the periodic cases. A spring and fall powder and liquid are made, although the powdered preparation is seemingly the most effective. This treatment should be tried in all obstinate cases. The immunizing treatment has a few advocates, and is also of undoubted value. There are two methods of producing immunization, first by graduated exposure to the irritating external cause, and this can be induced by bringing pollens or dust, or odors into the patient's room, or, second, by giving internally the tincture of the plant producing the pollen. Ragweed can be used satisfactorily in the form of *Liquor Ambrosia* (Curtis). Golden-rod tincture can be given in fifteen drop doses four times a day. It is not always possible to distinguish the particular irritating pollen, but when this can be done the method is worth trying. The latter manner of producing immunization is of course only applicable to the plant cases.

Recently Parke, Davis & Company, the well-known chemists, have advocated the mixed "Phylacogens" or modified bacterial derivatives in the treatment of hay fever, and they claim astonishing results. Should further observation substantiate these claims the result will be to entirely overturn our present conception of the causes of hay fever and asthma, and put them on a bacteriological basis.

Changes in location, for relief, are largely experimental. The pollen sufferers are relieved by a sea voyage, or by residence in a location near a large body of water where the prevailing wind is from this direction.

In the administration of internal remedies none have been found more effective than those given by Blackley in 1880: Potassium iodide, merc. iodide, arsenite of quin., arsenicum, arsen. iodide, sulphur. To this list I would add arsenate of strychnia, naphalin, sabadilla, grindelia robusta, allium cepa. and arum triph., according to their several indications. As our methods of treatment are not adequate in curing a large majority of hay fever sufferers, further study and investigation are of the greatest importance.—*Geo. B. Rice—New England Medical Gazette.*

**MACROTYS.**—The chief therapeutic uses of macrotys are: (1) Drawing muscular pain; (2) choreic and other inco-ordinated movements; (3) certain neuralgias and in rheumatism and rheumatoid affections; (4) painful and malfunctioning disorders of women; (5) and as a partus accelerator and remedy for the relief of disorders and distresses of pregnancy

**I. Pain.**—As a remedy for pain, macrotys is frequently indicated in the incipency of febrile attacks and in the acute infectious diseases. The general and often intense muscular aching which ushers in tonsilitis, pharyngitis and other forms of sore throat, la grippe, acute rheumatic fever, acute pneumonia and some cases of intermittent fever it is the remedy

of election. In purely acute rheumatic affections of severe type and confined chiefly to the articulations, we value it less highly than sodium salicylate, but often find use for it as an associate remedy. When the heart is threatened, it then becomes indispensable, for while its action closely resembles that of digitalis, it is devoid of the unpleasant nausea and possible dangerous cumulation of that drug. Moreover, it acts more rapidly. In rheumatic carditis, endocarditis and pericarditis it is invariably indicated. It regulates the rhythm of an irregularly and rapidly acting heart, and is, therefore, especially valuable in functional irregularities of that organ. In most painful conditions, if fever is present, one of the special sedatives—aconite, veratrum or gelsemium—will materially aid the action of macrotys, or may be imperatively demanded. The value of macrotys for the tensive muscular aching due to acute colds; in neuralgias of similar origin; in sciatica of rheumatic type or origin, or when due to cold, strain or exposure, but not when caused by pressure of an overloaded bowel, loose pelvic articulations or to fecal or other autointoxications; in myalgia of the neck, back and thorax; as the best agent in acute torticollis or spasmodic myalgia of the neck and shoulders; in pleurodynia; in rheumatic headache, and in ovarian and testicular neuralgia.

II. *Muscular Inco-ordination.*—Macrotys being motor excitant and antispasmodic, is a remedy of first importance in curable cases of chorea. Just how intimate the relationship between rheumatism and chorea is has not definitely settled. Many cases of the latter, however, are known to be associated with the rheumatic diathesis and tonsillar inflammation. When thus associated macrotys is one of the most efficient drugs to control the inco-ordinate movements. Prof. Locke employed a combination of macrotys and valerian, and this has also formed the treatment we have used chiefly. Dr. Gemmill, who has treated a large number of choreics successfully, uses macrotys, valerian and scutellaria.

III. *Diseases of Women.*—Macrotys promotes menstrual activity and facilitates the performance of the menstrual function. Moreover, it is tonic to the uterine musculature and appendages. For dysmenorrhea, in which the pain is tensive or drawing and the flow difficult, it is a remedy of greatest value. If amenorrhea or dysmenorrhea be due to cold or be accompanied with spasmodic muscular pain, macrotys and aconite are our best remedies. If these disorders be associated with pelvic congestion, the greater, then, is the need for macrotys; if there is congestion with leucorrhea, it may give relief if persisted in for some time as an intermenstrual remedy. When hysterical manifestations occur coincident with menstruation, or when the disposition to melancholia or to hypochondria is strong, and the dysmenorrhea is associated with congestion, macrotys will relieve as quickly as any medicinal agent.

IV. *During Pregnancy.*—The false pains, rheumatic or otherwise, during pregnancy, yield best to macrotys. Its action upon unstriated fiber is as specific as ergot, though the extreme contractions produced by the latter are unnaturally clonic, while those produced by macrotys more nearly resemble the normal throes of labor. Being tonic to the uterine muscle, macrotys is valued as an accelerator of parturition, and is a most admirable agent to provoke contraction during a tedious and muscularly inefficient labor. After labor it induces involution and prevents hemorrhage, being

for these purposes among the most valued of uterine medicines. Indeed, in most varieties of distress and pain associated with the function and process of child-bearing, from nervous irritability to erratic and nagging pains, so frequently an annoyance to the parturient, the sedative effects of macrotys are most beneficial. The nervous and mental aberrations having their basis in reproductive wrongs, such as acute puerperal mania and hysterical explosions, the sedative effect of macrotys, if administered early, is often sufficient to check.

V. *Cough*.—Finally, macrotys should not be overlooked as a remedy in cough, when the secretion is scanty and the spasmodic element pronounced. It mitigates the severity of pertussis and relieves a persistent bronchial cough of similar character; it relieves coughs which are dry and are associated with muscular soreness and marked nervous irritation.

The indications for macrotys are plain and simple: Tensive or drawing muscular pain and muscular inco-ordination. For all purposes except chorea and as a parturient, the fractional dose is most satisfactory; at any rate not more than one drop an hour. For chorea and in labor the full doses, 5 to 15 drops, as required, are most effectual. In labor it should be given preferably in hot water.—*Felter. Eclectic Medical Journal, Feb. 1912.*

LITHIUM CARBONICUM.—This drug acts prominently upon the mucous surfaces and muscular tissues and has a special affinity for the joints. Its principal use is in rheumatism and gout. There is undue dryness of the mucous membranes and itching of the skin particularly about the joints, and a roughness and dryness about the skin of the face. There is headache in the vertex and a pain in the left temple, which is relieved while eating and worse after eating. There is a characteristic eye symptom, namely, *the right half of objects vanish*. There is a dryness of the lids and the balls similar to that of *alumina*. There is a dryness in the membrane of the nose and the *inspired air feels cold*. *There is a red deposit in the urine*. Rheumatic affections about the heart, soreness, valvular deposits and an irritation of the cardiac muscle with shocks and jerks about the heart. Rheumatic tenderness and swelling of the joints of the fingers. The muscles seem awkward, and the patient is clumsy. The whole body feels stiff and sore; a puffiness about the body. Nodular swellings in the joints similar to those which we find under *benzoic acid*. Use the sixth trituration.—*Pacific Coast Journal Hom.*

THE TARENTULAS.—*Tarentula cubensis* and *Tarentula hispana* (although of the same family and thus apparently alike), still they differ widely in their pathogenetic and therapeutic effects.

The *Tarentula hispana* is a nervous remedy, acting deeply and powerfully on the cerebro-spinal system and many cases of chorea, hysteria, etc., have been cured by this agent. The symptoms produced by it approximate closely to those of chlorosis with hysteric complications, so much so that it is impossible to distinguish the two conditions. General debility, pallor of face, breathlessness, præcordial anxiety, palpitation, depraved taste, involuntary sadness,—these are common to both. Chlorosis has been known to supervene on the bite of a spider. The *tarentula* patient is



nervous, restless, requiring frequent change of position. *He must constantly busy himself or walk.* Nervous symptoms from uterine or ovarian enlargements. Hysterical insanity, deceptive, maniacal happy mood; terrible pruritis, a sensation as of insects creeping and crawling, especially of genitals. Symptoms are all better by violent exercise. Patient is disposed to play tricks, is fox-like and destructive, requires the utmost vigilance to prevent damage, moral relaxation, intense headache as if 1,000 needles were pricking into brain, relieved by rubbing head, as if large quantities of cold water were poured on head, great distress in cardiac region, vertigo, sexual excitement in both sexes, lasciviousness.

*Chorea* contortions do not even cease at night. Local hyperæsthesias (tips of fingers, etc.).

*Tarentula hispana*.—Patient seems soothed by the sight of bright colors, or by looking on smooth clear surfaces as water, but music is their great solace. Their bodies move to its measures as they are led to dance.

*Tarentula cubensis* seems to be a toxæmic remedy, acting directly on the blood. The bite itself is painless, persons bitten are not sensible of it until next day, when they discover an inflamed pimple surrounded by a scarlet areola. From the pimple towards some other parts of the body a red erysipelatous line is seen, marking the course followed by the spider over the skin after biting, so corrosive is the nature of the virus. The pimple swells, the inflamed areola spreads wider and wider, chills, burning fever, great thirst, anxiety, restlessness, headache, delirium, copious perspiration and retention of urine. Pimple grows larger, becomes a hard, large and exceedingly painful abscess, and having several small openings discharging a thick, sanious matter containing pieces of mortified cellular tissue, the openings forming large cavities. Now the fever takes on an intermittent type with evening paroxysms, accompanied by diarrhœa and great prostration. Now such symptoms describe plainly carbuncle, and it is here where *Tarentula cubensis* is indicated, for the atrocious pains and even when sloughing has commenced, useful in syphilitic buboes, tumors, scirrhus tumors of the breast, boils and all kinds of abscesses where pain or inflammation predominate. Its power to relieve pain in these cases is wonderful, acting, we might say, as an anodyne. It is the remedy for pain of death, pain of dying cells, last suffering, soothes the dying sufferer, pain, rattling in chest with no power to throw out the mucus. Use the thirtieth potency.—*Pacific Coast Journal of Homæopathy*.

NOTES ON MEDICAL GYNECOLOGY. Dr. W. H. Stiles in *Pacific Coast Journal of Homæopathy*.

*Colocynth*. Sharp colicy pains in ovary, intense burning pain causing her to double up. *Colocynth's* sphere of action is upon the ganglionic nervous system. The condition produced is one of irritation, resulting in neuralgia; but may pass on to true inflammation. The colicy nature of the pains are characteristic.

*Cantharis*. Much tenderness and burning in ovarian region; dysuria, with burning, cutting pains in voiding small quantity of urine. *Cantharis* acts more readily upon the mucous membrane than the serous. Its irritating effect upon the entire intestinal and urinary tract is so pronounced, in-

flammation may extend to adjacent parts, and is often useful in ovarian trouble.

In a case of pelvic disease in a woman, where there is much depression of spirits, and her mind dwells upon suicide, in studying the case how many of the systems besides the above calls for *aurum*?

Under *conium*, we have hardness and induration of the ovary with nausea, vomiting, and eructation of gas, white slimy leucorrhœa, and very probably induration of cervix. *Conium*'s strong indication is its well known action upon hardening and induration of the glands; and should be considered in scirrhus of the uterus and the ovaries with sharp lancinating pains, also in uterine polypi.

In pelvic or ovarian inflammation where you suspect exudation, pains sharp, worse on least motion, white coated tongue, what more potent than *bryonia*?

Let me also mention *merc. biniodide* to favor absorption of exudate. *Terebinth*, excessive tympanitis. *Cimicifuga*, rheumatic and hysterical cases, chronic form.

Old and familiar remedies, but there is a long list of them, and if studied carefully you will find them well suited to the equally long list of diseases peculiar to the uterus and its appendages in both acute and chronic form.

In cases of cysts of the ovary, tube or broad ligament, I am unable to state what percentage are relieved by our remedies alone. But look back over your work in the past, possibly before surgery had advanced to its present state of perfection, and do you not know that you did relieve many of these cases?

This I do not wish to be considered as argument against operation. It is a plea for a more careful selection of the similia, for conservatism in surgery, and to emphasize what seems to be a fact that many cases are operated that could be relieved by the more simple method and at less expense.

It is possible that, to the patient and to the family physician, the thought has come that if the patient be operated, they at least have had all that is coming, or the best there is towards relief. Certainly this feature should not enter into the matter. The necessity for and wisdom of operation should alone decide the matter. Because the patient is a trouble and an annoyance to you, is no reason why you should turn your patient over to the long-suffering surgeon to get rid of her.

It is with the general practitioner or the family physician that the fact is more particularly emphasized, of the considerable number of cases that are not relieved by operation, that return to them again for their care and attention.

STRONTIUM CARBONICUM.—It appears from the symptomatology of this remedy that it might be useful in arteriosclerosis. Strontium carbonate has a marked effect upon the circulation and produces many of the symptoms which go with sclerotic arteries. From the symptoms of the remedy it is safe to suppose that there is an increase in the blood pressure. Unfortunately this remedy was proven without the help which the modern laboratory methods give in the interpretation of symptoms, but with the imperfect symptomatology as we now have it it appears that strontium carbonicum may be a useful remedy in arteriosclerosis.

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## TUBERCULIN IN DIAGNOSIS AND TREATMENT.

BY

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(Read before the American Institute of Homœopathy, June, 1912.)

THERE are many tuberculins on the market, as shown by the accompanying charts:

For Active Immunizing.	For Passive Immunizing
1879 Tuberculinum, Swan.	Antisera.
1890 Bacillinum, Burnett.	1892 Dog serum.
1890 Tuberculin, Koch.	Horse.
1897 T. R. Koch.	Goat.
1901 B. E. Koch.	Paquin.
1892 Calmette's T.	1899 Maragliano.
1895 von Behring's T.	1903 Marmorek.
1898 B. F. Denys.	1911 I. K. Spengler.
1892 Tuberculocidin, Klebs.	1911 Mixed vaccines.
1897 Oxytuberculin.	
1900 Tuberculol—A.	
Tuberculol-B.	
1904 Perlsucht T.	
Albumose Free.	
Mixed T.	
T. Beraneck.	
1910 T. Purum.	
1911 T. Rosenbach.	

It will be seen that the word *tuberculin* was introduced in



modern medicine by the homœopath, Swan, back in 1879. Swan's *tuberculinum* is a potency of consumptive sputum, made long before the discovery of the tubercle bacillus and before the infectiousness of tuberculosis was generally recognized. Burnett's *bacillinum* is a trituration and subsequent dilution of the caseous matter of a tubercular lung.

In general medical literature, these homœopathic tuberculins are unknown. The word *tuberculin* means that series of preparations of tubercle bacilli inaugurated by Koch in 1890 with what is known as *old tuberculin* or *original tuberculin*.

You will note that a large number of tuberculins have been introduced since that time. You will ask why we need so many different kinds of tuberculin. The answer will surprise a homœopath. Because the original tuberculin given in large doses is toxic and aggravates the tuberculosis. The homœopath will say that, if it is worth anything, tuberculin ought to be toxic in large doses, that if it is toxic in large doses it will be curative in small doses; but Koch and his fellow bacteriologists have never grasped that homœopathic principle. All allopathic workers with tuberculin persist in regarding it as a pharmacist regards a plant, containing many principles, some inert, some curative and some objectionable. The clinical fact that tuberculin will cure some cases of tuberculosis and aggravate others indicates to them only that there are two principles in it, one curative and the other toxic. This long list of tuberculins introduced by as many enthusiastic experts is the result of the effort to so treat tubercle bacilli and their excretions as to isolate the hypothetical curative principle and discard the equally hypothetical toxic principle, for remember that the active principle of tuberculin has never been isolated. Whether there is only one principle or many principles is unknown. The preparation of these different tuberculins is pure guess-work.

I believe that the inventors of all these chemical and physical modifications of tuberculin are following a false scent. You and I find no difficulty in understanding that the toxic principle and the curative principle are one and the same thing, toxic in large doses and curative in small doses and sooner or later the bacteriologist will find it out. Practically, I disregard this long list of tuberculins and use only old tuberculin, bacillus emulsion and bouillon filtré as giving all the therapeutic power that can be obtained from any form of tuberculin.

The tuberculins in the first list prevent and cure tuberculosis

by producing active immunity, that is, the poison that aggravates the disease is administered to the patient. This is pure homœopathy. Those in the second list produce passive immunity, that is, an experimental animal has been made immune to tubercular poisons and the blood serum of this animal is transferred to the patient, carrying with it the immune bodies. This is not homœopathy. It is chemical or antidotal therapeutics. These anti-sera have enjoyed local popularity but have never come into extended use, except perhaps Marmorek's serum which has been used quite extensively in Europe. A novel variety on this list is I. K. or *immun Koerper* of Spengler, introduced within the past year. Spengler claims to have discovered that the immune bodies are manufactured in the red blood cells and only escape later into the serum. I. K. is a preparation of red blood cells of animals that have been immunized against tuberculosis. As usual, reports are contradictory with the chances strongly against its being of any use in the remedy.

#### TUBERCULIN IN DIAGNOSIS.

Tuberculin can be dropped into the eye, rubbed into the skin or injected hypodermically. The eye test should be abandoned or confined to veterinary practice. Cases of severe ophthalmia have occurred.

The skin test is useful in children under three years of age. After that time, the skin test is wholly unreliable.

The hypodermic test is the most reliable and also the most dangerous form if used in unsuitable cases. Koch and most European workers use a series of doses as follows :

First day .....	0.2 milligram.
Third day .....	1.       “
Fifth day .....	5.       “
Seventh day .....	10.     “
Ninth day .....	10.     “

As soon as reaction occurs, no more is given. Reaction consists of the usual rise in temperature, perhaps with headache, nausea, vomiting and general feeling of illness. The object of the series is to begin with a dose so small that it will not aggravate a sensitive case to use also doses large enough to cause reaction in the duller, less sensitive patients. My own practice is to make the diagnosis with one dose if possible. Such a series of doses is impracticable, unnecessary and may be harmful from

too frequent repetition. In this country, it is difficult to persuade patients to take more than one dose. I usually use a single dose of 2 to 3 milligrams, which will give all the information that is necessary from tuberculin.

Why not administer tuberculin by the mouth? By the mouth, it is inert. This is the experience of most tuberculin experts. At the Metropolitan Hospital, where we have hundreds of cases of tuberculosis, we selected patients that were sensitive to one-tenth of a milligram hypodermically but were unable to see the slightest reaction from much larger doses given by the mouth. In some cases we gave 10 milligrams, that is one hundred times the hypodermic doses, but without effect.

Before giving the diagnostic dose, take the patient's temperature every two hours for three days. If the temperature is 101 or higher, do not give tuberculin in diagnostic dose. It will cause a severe and perhaps a dangerous aggravation.

After the injection, take the temperature every two hours for two days. The patient should rest quietly in the house during this time. If the reaction to 3 milligrams is uncertain, only one-half degree rise of temperature, repeat the dose on the second day. Sharper reaction to the same dose is a tuberculosis reaction.

Do not inject tuberculin in diagnostic doses in patients who are losing weight or strength rapidly, or with tendency to hæmorrhage or hectic fever. In these cases, tuberculin is dangerous. The cases suitable for tuberculin are the early, non-febrile cases, the doubtful cases.

With children, the European practice is to use one-half the adult dose. My own experience agrees with that of Holt that one-half milligram is the most suitable dose for children, repeated on the second day if necessary.

I do not find it necessary to push the diagnostic dose up to ten milligrams. We know that a large percentage of the human race is tubercular. It is not necessary to inject large doses of tuberculin to learn that. We wish to know whether in a given patient, there is an active tuberculosis to account for the symptoms present. This can be learned from moderate doses of two to five milligrams.

#### TUBERCULIN THERAPEUTICS.

When tuberculin was introduced into therapeutics, two er-



rors were committed. First, the dose was too large, and, secondly, it was given too frequently. The first of these errors has been corrected. All tuberculin workers now begin with a very minute dose. The following table shows the doses most used to-day:

Koch and European  
workers.

Old tuberculin . . . . .	0.05 mg.
T. R. . . . .	.001 to 1 mg.
Bacillus emulsion . .	.0025 mg.

This dose is doubled every two days until strong reaction occurs. Then the increase is more gradual and the interval longer; with large doses, six weeks.

Deny's Bouillon filtré.

.000,000,01 c.c.
.000,000,1
.000,000
.000,01
.000,1
.001
.01
.1
1.0

The dose is increased by one-tenth to one-fourth c.c. every two days; when reaction appears, every four to seven days.

G. F. Laidlaw.

Old tuberculin . . . .	1.0 mg.
Bacillus emulsion . .	.005 mg.
Bouillon filtré . . . .	.000,1 c. c.

The dose is seldom increased and never repeated under one month, more often once in three months.

The error is still made of giving the dose too frequently. You will note that, in the Koch method, the dose is repeated every second day until very large doses are reached, when the interval is lengthened to four or six weeks. This interval is allowed not with the idea of permitting the improvement to continue but simply that these large doses are so slowly absorbed that a long time must be allowed for their complete absorp-

tion. Even Denys, the most intelligent of the bacteriologists, repeats the dose every second or third day until reaction occurs and then only waits three or four days before repeating. This frequent repetition of the dose is a serious mistake. Just as in the early days of tuberculin many patients were undoubtedly damaged by too large a dose, so, now, even in the hands of homœopathic physicians, I believe that patients are being damaged by the frequent repetitions of the dose of tuberculin. Tuberculin is a true homœopathic remedy. A large dose will produce a decided aggravation of the disease. In a case to which tuberculin is adapted, a small dose is followed by a period of improvement. Just as with a high potency of a homœopathic remedy, *it is important not to repeat the dose as long as improvement continues*. The diagnostic dose is my first therapeutic dose. I watch the patient one month, two months, three months and as long as improvement continues, give no more tuberculin. When improvement ceases, I repeat the same dose.

One final word about preparing the dose. In hospitals and in your own work it is convenient to be able to prepare the dose simply and easily without the elaborate mathematics ordinarily directed. I advise a method which I have used for five years with great satisfaction. Take an ordinary one-ounce bottle that has been sterilized, fill two-thirds with water that has been boiled, sterilized and cooled. Add one drop of old tuberculin, from the lip of the bottle always using the same sized bottle and lip so that the drop is practically the same. Shake thoroughly. Every five drops contains 1 milligram of tuberculin.

With the B. E. do the same thing. Mix one drop with two-thirds of an ounce of water. Each drop of the dilution contains .005 milligram, the usual dose.

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ADENITIS, TUBERCULOUS.—*Treatment.* Roentgen rays recommended for routine use in cases that do not readily respond to medical treatment. Give ten daily irradiations, then 2 or 3 times a week. Study of proper dosage in each case necessary. Patients thus treated early can be cured without breaking down of a single gland. Where such breaking down does occur, incise, swab out cavity with equal parts of iodine and phenol, and drain. *Boggs.*

**SOME THOUGHTS UPON THE LAYING OF THE FOUNDATION FOR A  
HEALTHY NERVOUS SYSTEM.**

BY

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As long as the majority of men are in a healthy state, they do not realize that they have nerves, but let them lose control over the most important or the governing member of the human economy, and they promptly go all to pieces, as the saying goes. We all know what the nerves are in a general way, but many of us do not know, or knowing fully appreciate, the association of the different nerves. For instance, we know that we have a nerve of taste some place in the mouth and nearby structures, but I fear do not appreciate the fact that the nerve of taste has a direct relation with the nerve of smell. We all know that we have ears, but do we realize that there is a certain nerve structure in the ear that helps to keep us from falling? (Organ of Corti).

Now, this little paper is not to be a technical discussion of these facts and theories, but a little talk upon matters that we know, but perhaps the most of us have not connected in our minds with other facts already known. Too long have we just simply followed after the teachings of the average practitioner of medicine, for he is not the man to-day that he was years ago. The medical profession, to a greater or less degree, is living upon the reputation of the forefathers, who, with the exception of the ministers were frequently the only educated men in the community. Now the times have changed, for the public at large is so educated that it is thinking for itself and the doctor and minister of to-day can no longer pose as the one man of greatest learning in the neighborhood, for often the patient knows really as much as does the physician. The public has come to think for itself. At the present time, many of the good meaning doctors have resolved themselves into distributing agents for the large drug houses. I do not mean to imply that there are no longer good doctors in the world, but to state that there are far, far too many who are simply following out what the agents of these drug houses tell them are the proper methods of treating disease. These agents come into the of-



fices of the practitioners and tell them of certain remedies and discourse upon the wonderful properties of the drugs. If the doctor be in the country, he buys directly from the drug concern, and if he be in the city, he sends to the drug store for the remedies, either for himself or by writing prescriptions for the patient to get filled. Many of the largest of the city drug stores do not really do their own compounding of the prescriptions as many of the things are made in bulk by some of the large chemical houses, and all that the druggist who is compounding the prescription has to do is to fill a few capsules or add a few things to a liquid, and in many cases to count out the number of tablets, capsules, etc., or to measure from a stock bottle the amount of the medicine that is wanted and the prescription is filled. This is no discreditable reflection upon the drug concern, as it is its business, but upon the medical profession who are permitting business houses to do their thinking. These things show the real degeneracy of the practice of medicine and pharmacy. The average practitioner has not settled for *himself* many of the things of medicine and the practice has resolved itself in a great measure into, "What can I make out of it?" Not that the author thinks it improper for a person to make money out of what he has put into money, time and brains, but that the business side of the profession is becoming over-developed, to such a degree in fact, that the real object of the practice of medicine is frequently lost sight of. The real doctor is ready to prevent disease as well as to endeavor to cure it. He will do all that he can in the way of prophylaxis that he can. This is done to be sure in many of the highly contagious diseases, but even in these diseases, when it becomes a personal matter, the average doctor will not be so careful—as for instance men, women and children who have been exposed to certain diseases have been rushed the whole breadth of the State so as to get home, thus exposing to the infection or contagion hundreds of innocent people. He is not the true doctor who will allow this. It is not only true of the germ and bacterial diseases but also of the nervous diseases, that the doctors should be taking some steps in a decided way to try to prevent many of the nervous affections, as they are in a great measure preventable, but how many of the people comprising the public are in a position to know how to prevent them? These things can only be understood after a study of childhood and temperament. It is hoped that those following

this discourse will bear these two things in mind during the entire discussion of the subject of this paper.

Before proceeding any further, it may be well to call attention to the physiology of the nervous system together with a little histology and anatomy. One very essential thing to all parts of the body, and of course the nerves is water, for it holds in solution many things, and holding them in solution it makes the economy better able to absorb nourishment as well as poisonous substances. Anything that will interfere with the fluids of the body will also affect the nourishment of the body for better or for worse. If anything interferes with the fluids of the body, the nerves must of necessity become affected in some manner, the same as will the other tissues and organs.

The nervous system is composed of a mass of separate but contiguous nerve cells, found by dissection to be connected throughout the entire system. The nervous system and the ego that we possess may be compared to a piano and the player. The player being the ego and the piano the nervous system and the strings the nerves through which the impressions and impulses travel. As long as the strings are in the proper relation and the ego presses the proper key, the proper note is sounded, but let some physical cause such as the displacement of some of the nerves (wires) occur then although the same pressure is made upon the certain key, there is not the proper note sounded. Thus it is with the nervous system when it has become deranged. There is the proper impulse sent out, but the body does not properly respond. Of course the ego must be taken into account also, for if the ego is not desirous of making the proper impulse the nerves will not. The physiological connection existing between the nerve elements in youth are **very incomplete** and poorly established. Growth will better establish them for better or for worse, and here is the necessity for the training of the child to see that the proper paths are made for the right impulses, and as the impulses travel more readily each and every time that they are made, they make such good connections that they become regular paths or channels for thought or action as the case may be.

The nerve cell has its peculiar make-up the same as all other tissue cells of course. The nerve cell has one or more prolongations known as dendrons (dendrites) and the particular prolongation that goes to form the nerve fibre is known as the neuraxon or neuron. The branch known as the neuron goes to

form the nerve fibre. It may or not have a sheath. Those composed of an axis cylinder are surrounded by a sheath in which there is a fluid. These sheaths are known as medullary sheaths. In the sympathetic system the number of sheaths is small. In the central system the mass of non-medullated fibres is small but the number is large. It is thought that the substance contained in the sheaths of some of these nerves assists in giving nourishment to the nerve. The real and almost constant source of nourishment for the nerve fibre is in the cell from which the fibre originates. In old age, and after disease, fatigue and misuses the nerve cell shrinks up and also the fibre and the result is the inability to receive or to transmit impressions or impulses as the case may be. As long as the individual has plenty of fluids of the proper kind in the body, the body will remain normal. Therefore, the necessity for plenty of water of composition to be present. As the nerves may be absorbed before old age, there is vital necessity of living natural lives and conserving the amount of water that is in the composition of the nerves, by the proper exercise of the nerves, for the proper exercise will keep the nerve healthy. It has been found that by lack of proper use, and of misuses that the nerve cell and even the fibre may be absorbed and disappear. Thus the necessity of living natural lives and conserving that water that may disappear and the anatomical structure of the nerves be lost or changed. The simple drinking of great amounts of water does not of necessity help the body—thus, for instance, in uremia, you may give all the water that will be taken and the case does not necessarily recover unless the kidneys are able to act. Not to be too technical, we will say that the nerves have their terminations in several ways—in little sub-divisions that pass between the epithelial cells, in motorial end plates in voluntary muscles, in special organs associated with special senses such as sight, hearing, etc., in various forms of tactile corpuscles, and sensory fibres may terminate in plexuses. If the nerves have their terminations in these places, anything that will derange these parts of the body will put more upon them than they were intended to stand and will draw upon the reservoir of vitality that has been given to us and the result will be the same as if we would withdraw the water from a dam. The only way to get back to the normal condition would be to rest until the reservoir would refill.

One fortunate thing in the human economy is that the cells



are able to recuperate by the process of rest. A certain amount of exercise is all right to keep the cells sufficiently active, but when they become abnormal or diseased the only true manner to restore them to the natural state is to let them rest in as nearly as possible the natural state and they will either throw off poisonous substances that they have stored up or they will rebuild the cellular material. Here is where the theory of the rest cure is proven to be the correct one. Drugs will stimulate or depress by one means or the other so that the cell is excited or depressed as the case may be and is left weaker than before in each of the cases, and in some cases the cell may be destroyed in the process of so-called physiological action. As the scope of this article is to be limited, we will not go into the details too deeply, but it is hoped that by discussion some of the points will be further enlarged upon or perhaps some new ones brought out that may be the basis of another paper. The thought that we are trying to consider is how to lay the foundations for a healthy nervous system. There are two distinct phases that will be discussed. First, the foundation that should be laid for the prevention of an undermining; second, the formation of a foundation after it has been undermined, or the reconstruction of it.

#### 1. Laying the good foundation.

Often in childhood, in fact in the great majority of cases in after life, the character of disease is more or less dependent upon the temperament of the individual and disease is frequently expressed in a magnified form of nerve expression. The child who has been raised up in the delusion of a Kris Kingle or the Easter rabbit will in many cases have some other superstition in later life. The child who is petted and spoiled and too much care taken of will not have the moral or physical ability to resist either disease or temptation. There is a certain amount of nervous force that is meant by the Almighty to be used and that amount will strengthen cellular life. For instance, many times a child will be peevish and the father or mother or attendant will to a great degree fail to make the child rest upon its own foundation. That is a very great mistake. The child should be assisted where assistance will be needed and not when the child wishes it. Too much is done in some ways nowadays for the children and the result is that in many ways they are not able to take care of themselves, while in the ways that they should be

helped, they are left to their own devices. Children are allowed to form pernicious habits that in after life make them morally and physically sick. Anything that will unnaturally excite the child should be avoided, whether in the form of exercise, eating or in study or play. These things, if not governed properly will have a bad effect upon the child in after years. Another thing that is often overlooked is the amount of rest that the average child is getting. Rest is an absolute essential thing for the young, as their cells need the strength stored up in them above what is needed for the immediate use for their future use and if sleep is not given them at the proper time they will become worn out. God made the night for man and beast to sleep in and He meant that we should do so or take the punishment. In the winter in this climate where the weather is so often inclement He made the days shorter and the nights somewhat longer so that we could get the proper amount of sleep after the exposure. When the summer comes and the reverse is true, we have longer days to enjoy the outside attractions in the way of air and flowers, greens, etc., as well as exercise and shorter nights to sleep in. Where the climates vary to any great degree as in the tropics and the polar regions, He has made the conditions such that there are not many men who would care to live there. Sleep—natural sleep is the gift of God and the loss of sleep is a sure foundation for some nervous trouble in the time to come. Rest as well as sleep is an important factor of maintaining the good nervous equilibrium. From childhood up we should rest when we are resting, so that the nerves may regain their normal state. One great cause of nervous breakdowns in the city business man is that when they go to bed, there are still various noises, that although they are asleep, the impressions are being constantly made upon the brain and in the end there will be some strain, that man, woman or child cannot stand constantly. That is one good reason why every city man should have a vacation even if he does not feel the need of it at that particular time, and also one of the best of reasons why the poor children of the slums should be taken away from the city at some time of the year. The Mosaic Law saw clearly the need of rest for all—man and beast.

Other things that should be impressed upon the doctor and layman of to-day is that our present day diet is not what it should be. Highly seasoned foods and drinks, sodas (especially sundaes) and the like are all exciting the nerve centers and

there will surely be a reaction. Combinations of food should be carefully looked into.

Another important thing that should be mentioned as being a factor in the forming of a healthy constitution of man or woman or child is that the growing child should be taught from the earliest age that is practicable that it should have a regular time for the evacuation of the bowels and bladder, and if this were done there would be far less of constipation, headaches, nervous troubles, misplaced and displaced wombs, auto-intoxications and so on. School teachers and others dealing with the growing generations should have the fact impressed upon them that there is a necessity for attention in this line as well as in blackboard teaching. Too often this is overlooked by many teachers that are otherwise very competent.

Sun baths are not to be forgotten. The skin has as one of its functions the throwing off of waste materials, some of which are similar to the urine. Clothing hampers this more or less and therefore it is wise for all individuals to have all of the clothing removed at some time of the day and to get the direct air and SUNLIGHT upon the skin, and God-speed the day when it will be that we may be able to have the air and sun baths without shocking the modesty of anyone. Places could be provided that would be as private as the average toilet if we would only want to have the proper provisions made in our own homes and institutions.

*Bathing.* There is a common idea that a person should all of the time be bathing. Now, bathing is certainly a good thing to clean the body and keep it healthy and in some cases to stimulate or depress, but the promiscuous daily bathing, regardless of the condition of the person is a thing that should be discouraged. Bathing, the same as any other form of habit, should be regular and should be done or indulged in with good judgment. It has been found by some of the very best men who have made studies of the nervous system that a great majority of nervous patients have been indulging in daily and sometimes two or more baths daily for months at a time. Others do not bathe enough. Too much bathing depletes or overstimulates the nervous system according to the kind of bathing, and thereby lessens the strength of the person by direct or indirect action.

Another thing that should be done to have a good foundation for a healthy nervous system is to have the teeth well



taken care of. It has been the experience of the author that many people have teeth that have required attention and that when these teeth go too long without the proper attention there is some reflex manifestation. It is well in the outset of nervous cases, especially in children to have the teeth well cared for, and in examining nervous cases to investigate the condition of the teeth.

Horace Fletcher has dwelt upon the mastication of the food to such an extent that it is needless in this paper to do more than to call attention to the subject in passing as being a good thing to do to help lay the foundation for a healthy body.

Impressions that are made upon the growing mind have a lasting influence and are so easily made that we should keep as much as possible the children away from nervous people, for the mental impressions have much to do with the nerve condition of the person in question, whether it be male or female, young or old. The proper amount of real study is good for the child, but not too much nor too prolonged.

Another thing is that the child should be examined for curvature of the spine. This cannot be too well looked after and the physical training should be directed to the proper development of the muscles of the various parts of the body.

Other physical defects such as adenoids, adherent prepuce, refractive errors and so on are being recognized to a far greater extent than they have in the past and should be highly recommended to be investigated.

In many ways, as the author has hinted, it might be very well if we were to follow more closely in the footsteps of the great Director of Public Health—Moses.

2. Turning from the consideration of the building up of a healthy foundation, let us turn for a few moments to the consideration of the relaying of the foundation or the building of a new one.

Too often in the treatment of nervous cases, too much stimulation is given. Of course stimulation will cause an apparent resuming of the functions, but it is FORCED and there will be a reaction, and the case is really further from being cured. On the other hand, perhaps a case is nervous and a sedative be given—the opposite effect is produced, but the case is also as far from being cured as the first mentioned. The only way to really effect a cure in nervous cases is to put the patient where Nature can use her own forces for the real cure of the case and

use as little medicine as possible and only other conservative methods of treatment. The keynote of the treatment of nervous cases is the rest cure. Rest enough to let the devitalized cells recuperate, and as little medicine as can be given to do the case justice. The avoidance of stimulants and depressers unless absolutely necessary should be practiced. These are the principles of building or rather re-building or repairing the foundation after it has been undermined. If Nature will repair the broken bone by throwing out a callous to help the doctor along, she will help in nerve affections as well, if the doctor will but recognize her laws. People must be trained to do these things and the doctor must first realize the importance of these facts before a nervous case can be rightly treated, or as in the early part of the discussion of the paper, the real healthy foundation be laid in the first place. But above all, we should realize that our own dispositions should be looked into and considered as a factor in all of our ailments, and we should impress this upon the public and our fellow practitioners.

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**RHUS TOXICODENDRON.**—Recent experiments have shown that the poisonous nature of poison ivy is contained in an oil which produces precisely the same effect as the plant itself. When a very minute amount is placed upon the skin, it is gradually absorbed in the course of a day or so, and that within certain limits the effect is proportional to the time of contact. In an experiment that has been performed the oil was applied to four places on the left wrist, and these were carefully guarded to prevent spreading. At the end of an hour one of the spots was thoroughly washed by successive applications of alcohol, in three hours, the oil from a second was washed off in the same manner, and the others were cleansed three hours later. There was little or no effect upon the first; that on the second was more marked, but did not equal that produced by the last two, which was about the same in each. The spots were within an inch of each other, but remained wholly distinct, a fact which very clearly shows that the affection is not spread by the blood. Subsequent applications of an alcoholic solution of sugar of lead gave speedy and permanent relief. In the treatment of ivy poisoning, it is not desirable to use strong alcohol, which is apt to be too irritating to a sensitive surface, but a weaker grade of from 50 to 75 per cent. is recommended. To this the powdered sugar of lead is to be added until no more will easily dissolve. The milky fluid should then be well rubbed into the affected skin, and the operation is repeated several times during the course of a few days. The itching is at once relieved and the further spread of the eruption is checked. The remedy has been tried in a large number of cases and has always proved successful. It must be remembered, however, that the lead solution is itself very poisonous if taken internally.—*Frederick M. Dearborn, A. B., M. D.*

**A PLEA FOR MEDICAL GYNECOLOGY.**

BY

JOHN RIETH, M. D., LANCASTER, PA.

(Read before the Goodno Homœopathic Medical Society, Columbia, Pa., Aug. 8, 1912.)

It is not my purpose here to antagonize my surgical brothers, but we all too often see descriptions of hair-raising gynecologic operations with wonderful survival of the patient. It is no doubt a great credit to the medical profession to have produced men with such wonderful technique and extraordinary skill as to enter one's very vitals and remove the most delicate organs. Surely we cannot bestow praise enough upon men with such marvelous accomplishments. But did you ever stop to think that there might be a patient now and then who, under skilled medical direction might have avoided such hazardous procedure and still have been cured?

We must agree that it is far better to spare a thousand guilty than to hang one innocent one. I believe that were we to use the same sound reasoning in our professional affairs that we do in the affairs of the state at least some of our patients would escape the necessity of an operation. I do not mean that all cases can be treated without the surgeon, but I do mean to say that a very large majority of our female pelvic affections can be so treated as to give the most startling results to both patients and physicians. Not more than fifty years ago all these pelvic affections were treated by the family physicians who made themselves famous. It does not seem reasonable in cases of acute inflammations or even in chronic varieties to remove the offending organ.

When we have a case of pericarditis or a case of pneumonia, were we to pursue the same course as we do with the pelvic conditions what would become of our patients? Now were we to treat these pelvic conditions as we do the thoracic conditions there is no doubt that our hospitals to-day would be less crowded and more women would be restored to health without the aid of a mutilating operation.

Now as to the medical treatment of the ordinary maladies of the female pelvic organs I want to say a few words in the defense of the much used and very much abused treat-



ment—the vaginal douche. I believe that more than half of the pelvic cases presenting themselves to us are due partially, if not entirely to the improper use of that procedure.

There are two chief uses of the vaginal douche to be commended, namely, cleansing and depletion. One caution I wish to draw your attention to is never hang the douche bag over a gas fixture or the top of the bed. Also under no condition should the bottom or lowest portion of the douche bag be more than two feet above the pelvis. To relieve the inflammation the water should be used as hot as the patient can stand and allowed to flow slowly in and out of the vaginal canal, the water of course being sterile, an antiseptic being added if deemed necessary.

The principal end to be obtained by the douche is one of depletion, with which of course it is necessary to keep the functions of the other organs active. The hygienic treatment is one to which too much attention cannot be given. Together with the douche we have also applications direct to the cervix and the uterine cavity, the vaginal pack and vaginal suppositories, the selection of which method and what remedy or combination being determined of course by the existing conditions the same as the selection of our internal medication.

If we carry out this line of treatment and wait with a little patience, our patients on a whole will make a satisfactory recovery. I do not wish to be understood as one who condemns surgery or who antagonizes the surgeon, but my purpose is to point out and impress upon the general practitioner that he may, with the same skilled use of his medical art as the surgeon displays with his knife cure a large percentage of his gynecologic cases and relieve suffering humanity with less violent means.

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BITES OF INSECTS.—Neal (*China Med. Jour.*) states that he has found the following procedure very useful: Take one ounce of Epsom salt and dissolve it in one pint of water, wet a bath cloth so that it will not drip and rub the body well all over, and not wipe afterward but dress, and flies, gnats, fleas, bedbugs, mosquitos, etc., will never touch you. If one is exposed more than usual, being near water, or in a forest, then make a somewhat stronger solution, wet a cloth and rub the face, neck, ears and hands well—do not wipe, but allow it to dry; it will leave a fine powder over the surface that the most bloodthirsty insect will not attack. Besides, the solution is healing and cleansing; it will heal the bites, subdue the consequent inflammation, and cure many diseases of the skin.

## Transactions of the Homoeopathic Medical Society of the State of Pennsylvania.

BUREAU OF HOMOEOPATHIC INSTITUTES AND CLINICAL  
MEDICINE

O. H. PAXSON, M. D., Chairman

### DIFFERENTIAL DIAGNOSIS AND TREATMENT OF SOME OF THE MORE COMMON DISEASES OF THE SKIN.

BY

PERCY H. EALER, M. D., PHILADELPHIA.

**STAPHYLOCOCCIA**—We thus begin with what probably is one of the commonest and one of the most simple of all diseases of the skin.

Among the older writers it was represented by the term *impetigo*, which, to-day, is fast disappearing.

The word *staphylococcia* is preferable, in that it advises more definitely regarding the nature and origin of the trouble. The condition is in reality a *pyoderma*, that is, an invasion by pus germs into an abraded, broken, or irritated skin. The infection is very characteristic.

While the lesions may be on any part of the body, more often they are found on those parts more easily reached by the hands—thus, the face, arms, hands, anterior surface of the body, etc. The lesions are irregular in shape and size, varying from very small spots to large areas, but the “sores,” so-called, are more or less covered with masses of dirty yellowish crusts. The development of the lesions is acute or rapid, and almost invariably an accompaniment of dirt and filth. It may be of primary origin, but more often it is secondary, or engrafted upon a previously irritated or inflamed surface.

*Treatment.*—The first essential thing is removal of all crusts. This should be done gently, and can be accomplished by the use of olive oil, or boric acid starch or paste, to soften the crusts. Following their removal, apply an antiseptic ointment, such as *hydrargi am. grs. xv* to an ounce of *petrolatum* or *zinc paste*.

**IMPETIGO CONTAGIOSA.**—This *impetigo contagiosa* is

another frequent skin condition, in some respects, very similar to the preceding trouble, so much so they are often mistaken for each other. A careful inspection usually reveals such differences, that they can nearly always be distinguished. The term *impetigo contagiosa* was supplied by Tilbury Fox. The condition is an acute, contagious, inflammatory disease, characterized primarily by discreet, flat superficial vesicles or blebs, rapidly changing to pustules and drying upon the skin as thin crusts.

The lesion starts usually as a flat vesicle, less often a bleb. The change from a vesicle to a vesico pustule, or even a pustule can occur in even a few hours. In size the vesicles are usually small and not distended; they have sort of a wrinkled appearance, and the epidermic covering is so thin the least pressure will cause it to rupture. Often there is no inflammatory areola around the vesicles, and the contents in drying have a thin wafer-like crust of straw yellow color. At times the edges of crusts loosen and curl up, producing the "stuck on" appearance of Fox. After healing there is left a reddish spot, which disappears in a few days. Irritating applications may cause the lesions to coalesce, causing large patches. As a rule only the exposed surfaces are the ones involved—the face, hands, neck—but any part of the body can be attacked.

VARIETIES OF IMPETIGO—We are rejoiced that the tendency of dermatologists to-day, in their descriptions, is toward simplicity and accuracy of cause. Formerly when a case appeared with the lesions circular or annular, it was regarded as a separate variety, and called *impetigo contagiosa gyrata*. Again, if the lesions were in larger blebs it was known as *impetigo contagiosa bullosa*. They are variations of one and the same disease. The latter is more virulent, having at times been epidemic in institutions, with an occasional fatality.

Duhring, a number of years ago, applied the term *impetigo simplex* to lesions that from the beginning are pustular, have thick walls, are globular, do not lead to rupture, coalescence or umbilication—at that time too, he thought it was non-contagious.

In the evolution of classification going on, *impetigo staphylogenese* and *impetigo* of Bockhart have been suggested. The latter is probably the better, because of Bockhart's description of the trouble. The peculiarity of this variety is, that the lesion is a pustule from the beginning, never a vesicle; the pus-



tules are penetrated by hairs, therefore have their seats at the mouths of hair follicles.

This condition is similar, if not identical to the pustular folliculitis that complicates nearly all severe cases of small-pox, during the stage of decrustation, or, less frequently severe attacks of chicken-pox. These forms have been called *impetigo variolosa*, or *impetigo varricellosa*.

*Pathology.*—The term *impetigo*, as we have already stated, is no longer broadly used as formerly, including, as it did, anything due to pus inoculation. To-day there are only two varieties thus recognized, viz., the *impetigo* of Bockhart, and that of Tilbury Fox, the *impetigo contagiosa*. Cultivations from the initial lesions of the latter have given staphylococci, but Sabouraud claims by special cultivation to have obtained pure streptococcus pyocyanus.

The *impetigo* of Bockhart is due to inoculation of the pilosebaceous follicles with pyogenic cocci, and these Bockhart asserts are pustular from the beginning.

*Diagnosis.*—In distinguishing these conditions, in *impetigo contagiosa*, observe especially the superficial character of the lesions with very thin crusts.

In the very early stage, a small vesicle thinly covered, easily ruptured, following which you see the basin has no depth, it seems almost on top of the skin. In *staphylococcia* the epidermis is usually more deeply broken, considerably more crusting, and of a dirty yellow color. Another point of differentiation, *staphylococcia*, while auto-inoculable, is not readily transmitted.

*Impetigo contagiosa*, as its name implies, is highly contagious, as well as auto-inoculable.

In the *impetigo* of Bockhart you have an involvement of the hair follicle, giving the appearance of small or tiny abscesses surrounding a hair.

PUSTULAR ECZEMA occurs in patches, with a reddened base, much more itching, and is more resistive to treatment. *Vari-cella* has the vesicular beginning, is often accompanied by fever, and it attacks by preference the covered surfaces, whereas these conditions attack more often the exposed areas and uncovered parts of the body.

PEMPHIGUS has blebs—usually large ones—but it is a chronic condition, and you readily see that you have a very ill patient. The contents of the blebs are not inoculable.

*Treatment* is similar to the preceding staphylococcia. First, soften and remove the crusts, and apply an antiseptic ointment. Hydrar am. grs. x or sulphur grs. xxx or lx to the ounce of petrolatum.

In some cases a better result is obtained by using a lotion, viz., lotia nigra, or the following:

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Resorcini, phenol, boric acid, glycerine, each  $\mathfrak{z}$ i, zinc oxide  $\mathfrak{z}$ ii, aqua q.s.  $\mathfrak{z}$ iv.

Apply several times daily.

VACCINIA—Under this name following vaccination, various skin lesions and all sorts of eruptions have been reported, we believe erroneously, that is, the vaccination is responsible for the vesicle, and pustule only. The other manifestations are extraneous thereto and due to a mixed infection—prominently among the most common is our friend, the *staphylococcus*.

We do not propose to enter into the pros and cons of vaccination and anti-vaccination. Our purpose, instead, is to offer a suggestion or two, that we believe will obviate much of the trouble, and eliminate much, if not all, of the danger arising from the mixed infection liable to attend vaccination.

Dr. Schamberg, a few months ago, called my attention to a preparation he had suggested, and which had been used in all of the municipal vaccinating. At that time it had been used in several thousand cases. While too few to lay claim absolutely as to what it will do, there is good ground for giving it a trial. As Dr. Schamberg said, the weak point about vaccination is the lack of care and attention these cases receive from the physician subsequently. His plan is, twenty-four to forty-eight hours after vaccination, to begin painting the scarified surface and several inches surrounding it with a solution containing 4% iodine and 2% picric acid, in 95% alcohol.

I have used the preparation a number of times since, and have been pleased with the result. There is no interference with the formation of the vesicle and vesico pustule. Where the change occurs is in the lessened inflammatory areola. My cases have had no cellulitis or lymphangitis, nor have the children shown as severe systemic reaction, represented by fever, nausea, etc., and altogether much less painful arms.

My plan of vaccination is as follows: Cleanse the arm, scarify the surface perhaps  $\frac{3}{8}$  of an inch in diameter, until there is free oozing of serum.

I use a needle, and pressing very lightly upon the point, it is practically painless, even infants asleep have not been awakened. Then with a clean piece of gauze mop away the serum, leaving a dry surface upon which to place the vaccine virus. This little point I consider valuable, and believe many failures in the "take" is due to an excess of serum oozing and washing away the virus. I then place one of the "Mulford's perforated shields," and outside of which a gauze bandage. These I remove in twenty-four or forty-eight hours, and paint lightly over the scarified surface and for several inches outside, with the iodine picric acid solution, continuing it daily until healing is accomplished; also have the caretaker of the child daily place a clean piece of gauze or linen so as to protect the vesicle from the clothing.

When we look over the history of vaccination, we can hardly blame parents for fearing it; even if there were but one death in a million from tetanus, we would not wish to be the sacrifice, and as a physician I have witnessed my one.

*Acne* may be defined as a parasitic involvement of the sebaceous glands of the face, and upper trunk, causing an inflammatory condition, which may be acute, but is usually chronic. It is essentially a disease of adolescence, consisting of comedones, accompanied or followed by more or less supuration.

*Etiology.*—There is no longer any doubt, but that acne is the product of the acne bacillus, the micro bacilli of Sabouraud and Unna. There is a question as to whether the starting point of acne is not due to seborrhea. It is claimed that during adolescence, the sebaceous glands are proportionally large, which accounts for the oily skin of so many patients, the so-called seborrhoea oleosa, and which also explains their proneness to attacks of acne.

*Pathology.*—The comedones, the worm-like masses of hardened sebum cells, is from the lining of the pilo-sebaceous follicle, black or dark brown in color. It was formerly thought that the blackhead formation was due to dirt and debris; instead it is the action of the micro organism itself. Pustulation in the later stage is due, it is said, to the same organism, and has been called a "bacillogenic impetigo." Where ordinary pus germs are present, it is probably a secondary infection. Acne lesions are both superficial and deep, the latter extending at times into the corium; here besides the inflammatory infiltra-



tion surrounding the drop of pus will be a dense mass of granulomatous cells of various kinds, and also connective tissue spindles. This cellular infiltration accounts for the nodules of old acne, and the failure at times to find pus on their incision. Organization occurs frequently, also scarring. This cicatrization is often a disfigurement, equaling almost the pitting following small-pox. Certain patients appear to be very susceptible to this complication. The diagnosis of acne is easy, but certain therapeutic eruptions closely simulate it, *e. g.*, the bromide eruption is one—the iodides cause a pustulation resembling it. Chlorine produces a severe lesion.

In acne the comedo is the starting point, and is the centre of every pustule—other pustular diseases have no necessary relationship to the sebaceous glands.

*Treatment.*—The disease is so common, forming almost ten per cent. of skin troubles; the slow or poor results, often attending our efforts is perhaps a reason of our lack of interest in combating the disease. To the ones afflicted, however, the eruption appears at a time in life when even its simplest form is looked upon as a serious handicap, to say nothing of the irreparable scarring following the deep nodular lesions.

The majority of the cases can be cured, but unfortunately there is as yet no specific. Theoretically, the vaccine injections should achieve brilliant results; in certain instances they do, but the failures are sufficiently frequent to hold them in reserve. So with the X-rays, valuable at times, but it must always be borne in mind the danger from over-treatment and the atrophic conditions arising therefrom.

The time of life with these subjects might not inaptly be called the *qui-vive* period—their development in every direction is progressing rapidly, everything is excitement and stimulation. The amount of oil poured upon the skin of these patients from the over-worked sweat coils and enlarged sebaceous glands is noticeably increased..

Facial hyperemia is more constant, due to vasomotor excitation through the emotional centres. In a good many it is the period when masturbation is practiced most. All of these conditions are factors in the susceptibility to acne. The principle of our treatment, therefore, must be toward the calmative and sedative as well as antiseptic.

In diet, avoid or reduce to a minimum all excitants. No alcoholics, very little tea or coffee—avoid rich or fatty foods,

excess of sweets of all kinds—allow sparingly of lean meats—complete the menu with milk, green vegetables and fruits. Have patient take part freely in physical culture, but no training for contests. Athletics of right sort help also to control excess of sexual desires.

For the acne lesions *per se*, first of all the comedones must be removed. This must be done faithfully and daily, with as little injury to the skin as possible. Schamberg's comedo extractor is excellent, but one can succeed admirably with a steel hairpin—placing the curved end above the comedo, making pressure and traction against it. A little practice soon enables us to catch on—to the comedo.

Daily application of warm water and soap, thoroughly applied, seeing to it that all the soap is removed from the face by sufficient water. Then follow with your lotion. In the majority of cases avoid ointments and salves. A very excellent lotion is zinc sulphate and potassium sulphide, each 4% to 6% in water, to which add 20% to 25% of 95% alcohol.

If the face has been made sore and painful by irritating applications or pinching of pustules, we must begin with a more soothing lotion. Here the following is useful:

R

Resorcin, boric acid, glycerine, aa*ʒ*i, pv. zinc oxide  
aqua hamamalidis f*ʒ*iii, aqua g.s.f. *ʒ*ii.

A last word. In all cases of acne do not fail to examine *scalp* for seborrhoea and treat *it* if you would cure the acne.

SYCOSIS VULGARIS may be defined as a pronounced inflammatory disease of the hair follicles, with certain characteristics that differentiate it from other forms of pustules, etc. The disease usually attacks only the bearded regions, therefore practically a man's disease. Perhaps the favorite site of all is the upper lip, just below one or both nostrils, and very often accompanied by a nasal discharge which often is the source of the infection. The lesions begin as papules or pustules, or, if larger, as tubercles, but always perforated by a hair.

*Etiology*.—In a large majority of cases the evidence is that the staphylococcus aureus is responsible. Sabouraud, Unna and others have proven this. Sabouraud furthermore says that where this micro organism causes the initial lesion it does not tolerate the presence of a secondary infection. But it is also true that a good many cases are of a mixed infection. He also

points out that the weak points in the epidermic armor are the mouths of the hair follicles—these with the disintegrating effect upon the horny layer caused by exposure to heat, cold, etc., and the traumatism produced by shaving, rubbing, or even washing have to be regarded as predisposing factors. The wonder is that more cases are not produced.

*Pathology.*—While sycosis begins apparently as an ordinary folliculitis, that is, an inflammation about the mouth of the hair follicles, its true characteristic is its ability to penetrate down along the follicle into the deep portions of the skin, and also perifollicular structures. This deep involvement leads to its chronicity, and aids in explaining the difficulty of reaching the bugs through the external applications. As a diagnostic point keep in mind that in sycosis the follicle is attacked first, and the hair itself secondarily. Early in the case the hair extraction is difficult and painful; later the hair comes out easily with root swollen and covered with pus. In *ring worm* the hair is primarily attacked.

*Prognosis.*—A majority of the cases can be cured if the patient will persist. The disease is refractory, recrudescence is common, but nevertheless persistence will overcome and finally cure.

*Treatment.*—There is no specific. The internal prescribing must include all general derangements. The external treatment is the more important. If there is a nasal catarrh it must be corrected. First of all, clip the hair as short as possible, and keep it short by repeated clipping. If pustulation is present and free suppuration, daily depilation. If unusually fortunate in seeing the case in the very beginning, hot boric acid compresses may abort trouble—not often. In later stage with papules or papulo-pustules, paint with tincture of iodine or iodine 1 part, balsam of Peru 7 parts, followed by ointment of sulphur 5ss-5i, or hydrar am. grs. v-xv, ichthyol 3i, petrolatum 3i.

The injection of vaccines has been attended with brilliant results in some cases—in others not. X-ray treatment has been successful where everything else has failed; however, err on the side of caution rather than have an atrophy followed by irreparable baldness.

*TINEA SYCOSIS—Ringworm of the Beard.*—This disease superficially somewhat resembles the preceding affliction. It is an acute contagious inflammation, attacking directly the hair—subsequently the follicle. It is due to an invasion by the



ectothrix and endothrix trichophytos. This vegetable fungus is most frequently brought to the patient by the shaving brush and the hands of the barber—although it is possible to contract the disease from horses and cattle. The mycelia and spores attack primarily the hair—the surrounding folliculitis occurs by extension, and this fact aids in differentiating ringworm from sycosis vulgaris.

Usually in the beginning will be seen a small, roundish, reddened and scaly patch, in which close inspection will probably reveal broken hairs, and hairs that can be very easily extracted, and they are dry.

In the other form of sycosis it is not until suppuration has developed that hairs can be pulled out painlessly, and the roots are swollen and covered with pus.

In tinea sycosis the pustulation occurs after the follicular involvement, the amount of pus and crusts or other detritus depending upon the neglect or maltreatment previously. In all diseases of beard and scalp, an examination of hairs should be made under the microscope.

With applications of a few drops of 20% to 25% solution of potassium hydrate, the mycelia or spores, if present, can be detected.

*Treatment.*—In principle it is parasitocidal. Crusts soften and remove—daily epilation of hairs—free use of soap and water, followed by application of iodine or germicidal ointment.

R

Resorcini 10% to 50% in paste—*i. e.*, pv. zinc oxide, pv. amyli each one part, petrolatum two parts.

This has been recommended especially where epilation was difficult to carry out.

In preparing this essay the following authorities were consulted: Schamberg, Stelwagon, Sequeira, Macleod, Jackson, Walker.

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BURNS.—*Treatment.* Dry open-air treatment of extensive burns recommended. After thoroughly cleansing with soap and water and gasoline (under anesthesia, if necessary), dust burns lightly with zinc stearate powder. Give morphine to relieve pain. Once daily remove all heavy crusts, wipe off exudate with dry sponges, and dust on thin coating of powder. Never allow exudate to accumulate under crust over twenty-four hours. Success of treatment lies in constant absolute exposure of the burn.—*Jack.*

**ARTERIO SCLEROSIS.**

BY

C. DUDLEY SAUL, M. D., PHILADELPHIA.

THE enormous trackage of the arterial system and the fact that any part of this system may be subject to sclerotic changes, with possible clinical manifestations too often obscure, makes the study of this disease, or pathological condition, difficult and interesting.

So many conditions and factors enter into its etiology, that upon the very threshold of a study of arterio sclerosis we are confused. Old age, alcohol, syphilis, the infectious diseases, are the chief factors upon which stress is laid in medical literature. Drs. Thayer and Brush, in reporting 4,000 cases in which the radial artery was palpable, give hard manual labor, rheumatism and alcohol in the order named, the chief etiological factors. Dr. Cabot, on the contrary, in reporting fifty post mortems upon dipsomaniacs under fifty years of age, states that only 20 per cent. showed any arterial degeneration.

Too little importance is placed upon the toxæmia of over-eating and sedentary life—with its continued hypotonus, tending to arterio sclerotic changes.

The disease is occasionally met with in early life, when no cause is ascertained and is theoretically explained by Hirschfelder "as an inherited lack of tonicity of the vessel walls, tending to senile changes."

The clinical manifestations of arterio sclerosis may be so varied, depending upon the part of the system affected and the degree and distribution of pathological changes in that part, that a definite symptomatology is hard to attain, except as to the more gross conditions, which are common to nearly all advanced cases.

Probably the earliest symptoms, pathologically and clinically, are the changes to be found in the terminal vessels of the eye—whether this be true solely because we are able to study with the ophthalmoscope the terminal vessels here and not elsewhere, I do not know.

The ophthalmoscope shows tortuosity and changes in the calibre of the vessels—an unusual light color of the artery and changes in the course of the veins. Later the appearance of

white stripes along the arteries and veins and the loss of translucency. These changes are usually early and I feel that an ophthalmoscopic examination of all patients over forty should be an essential part of our routine. These cases as a rule will have momentary blurriness of vision and slight attacks of dizziness. The importance of these examinations can be best demonstrated by a case in mind. Male, age 52—locomotive engineer—complained of depression, occasional slight dizziness and momentary blurring of vision—particularly after a long run, the continued jarring of the engine aggravating these symptoms. The arterio sclerotic changes in the retinal vessels were marked. This condition is not necessarily incompatible to old age in this man, but to the thousand people upon his train—an attack of vertigo—a blurring of vision—at a critical moment, may cause untold disaster. A physical examination without the ophthalmoscope, which I presume railroad engineers are given, would show nothing to prevent this man continuing his employment.

The blood pressure in arterio sclerosis is usually high. A high systolic and low diastolic is the rule—that is: a high pulse pressure—although marked arterio sclerosis is present at times with low systolic pressures. The value of blood pressure in arterio sclerosis, as in any other condition, is of use only when all the factors which may influence blood pressure are considered; a numerically low pressure may be relatively high, and vice versa.

Changes in the aorta are common, an accentuated aortic second sound, due either to the high tension or to sclerotic changes in the valves themselves. A systolic murmur transmitted up the carotid and not accompanied by a thrill as in aortic stenosis, may be present. Such a murmur in young adults is most invariably an aortitis of syphilitic origin.

A rough systolic murmur with its point of maximum intensity in the pulmonic area, is diagnostic of arterio sclerosis of the pulmonic artery and is secondary to sclerotic changes in the aorta.

Sclerotic changes in the coronary arteries produce a chain of cardiac symptoms not fully understood, the symptoms probably depending, however, upon the degree and distribution of the sclerotic bands.

The secondary effect of these changes in the coronary arteries would be a diminished blood supply to the heart muscle.



As a heart, under exertion, requires more blood to its muscle, the effect upon it of a diminished blood supply in its time of need would manifest itself in a tachycardia, pain, cardiac dyspnoea, angina pectoris, or in a sudden ischaemia and death. Many of these attacks are coincident with a sudden rise of blood pressure and follows exertion; rest and lowering of the pressure affording relief.

A typical case of angina was reported in our medical dispensary last winter, with such severe pain, first along sternum, then over the entire chest and extending down the left arm, that the woman was hardly conscious of her surroundings. The systolic pressure was 285 and diastolic 180. Sclerotic changes were marked and the cardiac muscle showed degeneration and hypertrophy. This woman, providing she takes no strenuous exercise and keeps her blood pressure as low as 250, is free from anginal pains—running up and down stairs or working an hour at the wash tub brings on an acute attack.

Nitro glycerine is probably our quickest and most efficient remedy to reduce these enormous tensions—and it often requires very radical dosage. Dr. Williams reports a case of angina in which he used 35 tablets of 1-100 grain each to abort the anginal attacks.

The heart, in arterio sclerosis, is usually hypertrophied, and displaced downward. Acute dilatation may follow a hypertrophy producing symptoms of cardiac insufficiency. Through the weakening and thinning of the arterial walls, aneurism may be developed during the course of arterial sclerosis.

The cerebral symptoms are varied, from slight vertigo to unconsciousness, with slow pulse and mental depression, or cerebral hemorrhage as the smaller arteries break. Transient hemiplegia and aphasia with complete recovery has been noted.

Renal symptoms are common and it is often a difficult matter to determine which is the primary factor, the nephritis or the arterio sclerosis.

Gastric symptoms are often present—crampy pains of the abdomen and of the calves of the legs at night occur in quite a number of cases. Sclerosis of the uterine vessels has recently been brought to our attention by the gynecological pathologist, as one of the many causes of uterine hemorrhage.

The treatment of arterio sclerosis must be preventive as far as possible; recognizing that degenerative changes may take

place following the course of the infectious diseases, such as typhoid, rheumatic fever, syphilis, etc., by carefully watching these cases, and by repeated examinations of the heart and palpable vessels, by prolonging the period of rest, warning of the dangers of too early return to active physical work, and by a careful supervision of the diet of these convalescents for a period of months, the degenerative changes may be avoided—a constant watch kept upon the blood pressure is of the utmost value.

A more liberal use of the stethoscope and observation of arterial vessels, during the course of early syphilis, would do much to prevent the sclerotic changes later—as it is during the early stages of the infection that these degenerative changes begin, although their serious effects do not appear till later.

Arterio sclerosis of syphilitic origin is of course treated by syphilitic remedies—chiefly iodides of potash, a plain diet, free from meat, frequent bathing, suspension of exercise and careful watch over the blood pressure—to avoid undue high tension, and frequent examination of the urine for kidney lesions.

Plumbism is a frequent cause of sclerosis, and the treatment would be directed against the lead poisoning by elimination and a prompt change of occupation. In the senile type the arterio sclerosis of the aged, treatment is unavailing—rest, a low diet, daily routine free from mental or physical excitement, lest the worn-out arteries of the brain break, the avoidance of higher pressures—is the little that can be done. “We cannot turn back the hand on the dial.”

In the class of cases which develop arterio sclerosis due to continued high tension, independent clinically of renal disease, much can be done, not only in the prevention of apoplexy, but also in the prevention and spread of the arterio sclerosis. These cases are not always the fat gourmands we are apt to picture, but often small, thin chaps, whose pot bellies consume enormous amounts of food and drink, and whose chief exercises are using the fork and lighting a cigar.

Probably the most important point in reducing the continued high blood pressure is diet. Moderation is absolutely essential. The diet should be plain—and mixed, not essentially vegetarian—but meat is to be eaten sparingly—and never more than once daily—fish may displace meats altogether. Secondly, a diminution in the quantity of liquids consumed.

Constipation is to be shunned. The salines are valuable. Calomel in small doses at intervals more so.

In certain cases venesection is undoubtedly of value and advisable. When spasmodic dyspnoea occurs the nitrites may be administered, when such dyspnoea is due to sudden rise of the arterial tension. Sodium nitrite with bicarbonate of soda is valuable.

Iodide of potash as a reducer of blood pressure is not always certain, nor its effect upon the tension regular. Yet in some instances it does remarkable work, as in the case of ganina mentioned in this paper. A course in the German Spas, Bath, Neuenahr, Royat, Mauernbad or Carlsbad is to be advised—probably the effect of travelling so far for treatment and its cost to the average American has much to do with its results, particularly as the patient is apt to follow explicitly the regime given him more carefully than he would follow that of his medical adviser at home.

To sum up: The treatment of arterio sclerosis should be as in other diseases, preventive.

It is the duty of the general practitioner to educate the laity to the importance of physical and laboratory examinations in health at frequent intervals. As it is by this means only that deviation from the normal can be grasped in its incipency, and, furthermore, the only way that the physician can determine what is normal or abnormal to that individual. "Had we seen this case earlier, he might have been saved."

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#### DISCUSSION OF DR. SAUL'S PAPER.

Dr. Wm. R. Williams:

Arterio sclerosis is a subject of vital importance on account of its protean manifestations. It is well said that if we live long enough we will all die from it. In these days when so much attention is given to the maintenance of good health, when the public is alive to the value of frequent physical examinations during and after middle life, even in the absence of impaired health, the earliest inroads of arterial degeneration may be detected and prophylactic measures instituted to prevent or at least retard its further development. The prophylaxis of arterio sclerosis may be summed up in a few words; the prevention and elimination of circulating poisons



and toxins, the moderation of the stress and strain of modern life, and the careful supervision of the diet, hygiene and work.

Once established, its treatment resolves itself into that of its complications,—be they of the heart, kidneys or brain.

Too much attention, I am sure, is paid to the existence of high blood pressures in these days of its easy estimation. Attacking a high blood pressure should be undertaken cautiously and only after every effort has been made to prevent and eliminate circulating poisons from intestinal absorption or the specific poisons of lead and syphilis. However in certain cases, where high blood pressure is undoubtedly a menace, and particularly where we have those sudden exacerbations of blood pressure, with the possibility of irreparable damage to the brain or heart, the pressure must be carefully supervised and at times vigorously attacked.

The case of mine to which Dr. Saul has referred, which required large quantities of nitro-glycerine (as many as thirty-five 1-100 gr. tablets daily) was an angina due to a syphilitic aortitis with aortic regurgitation and developing stenosis, and obstruction of the mouths of the coronary arteries. Only so long as the blood pressure was kept below 160 was the patient comfortable. A marked general arterio sclerosis was associated.

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### CARDIAC ASTHMA.

BY

S. M. RINEHART, M. D., PITTSBURGH.

ASTHMA, or spasmodic dyspnoea, is a term that covers many conditions having their origin in a diversity of causes. Cardiac asthma is a name defining a symptom-complex, not a disease, and is distinguished from other asthmas not only by its symptoms, which superficially may be similar, but by the causal conditions, which are totally different. To the ritualistic prescriber it may seem a matter of indifference whether, having a symptom-picture presented to him by the patient, the fault lies in the air tubes, as in bronchial asthma, or in the heart, the arteries, or the kidneys, as in cardiac asthma. But unless the physician knows these facts he will have difficulty, not only in arriving at a proper idea concerning the actual condition and the prognosis, but he will fail to get the totality of symptoms.

In order to bring the subject of this paper more concretely before you, let me give you a hypothetical case as a text. To you in your consulting room comes a patient with this history: He is over sixty years old and of normal appearance, except perhaps, for a tendency to stoutness. Several months ago he began to notice a slight oppression in the chest on walking fast, and this oppression with more or less shortness of breath on exertion, have increased gradually ever since. About a week ago he was awakened one night by a tightening in his throat and a feeling as though he would "choke to death." This dyspnoea drove him from bed and compelled him to sit up for a while, after which the labored breathing gradually subsided, the cough, which was dry and occasional in the beginning loosened, his anxiety abated and he was enabled to go back to bed. Two or three nights later he had a similar experience but instead of one attack he had several, and on the night following the first recurrence he refused to go back to bed altogether, dreading a repetition of the night before.

Your diagnosis is "asthma" and you prescribe for him conscientiously according to his symptoms, both objective and subjective. However, unless you go more deeply into his objective symptomatology than the average practitioner is wont in routine practice, you may miss that finer, more intelligent and satisfactory diagnosis which, with all due respect to the indicated remedy, would enable you to do your whole duty by your patient. If you are methodical you will endeavor to get at the underlying causes of this condition as well as to relieve him by the proper symptomatic remedy.

You will feel his pulse not for rate and rhythm alone, but you will note a slight rigidity of the artery and a little less than normal compressibility. You will observe the condition of the temporal arteries. Baring his chest, you notice that the apex beat is a little to the left of the normal position, and, on percussion, that his area of superficial cardiac dullness is, perhaps, 19 cm. wide, most of the excess being to the left of the mid-sternal line. There may or may not be a heart murmur. For our hypothesis it is immaterial. His blood pressure you find to be 180 mm. This leads you to suspect a possible chronic kidney lesion in connection with a beginning arterio sclerosis. Your heart findings would indicate a hypertrophied left ventricle. On examination of his urine you find the total amount in twenty-four hours is twice the normal quantity, with less

than the normal amount of solids; also a trace of albumin and many casts.

Now your diagnosis is not merely the indefinite term, asthma, but cardiac asthma, due to a arterio sclerosis and chronic interstitial nephritis with their consequent effect upon an over-worked heart. And you know that his sudden awakening and subsequent distress were due to the air-hunger caused by inability of a weakened left ventricle to perform the increased labor devolving upon it. With this knowledge, your treatment will also be directed toward checking the progress of the kidney lesion and of the degenerative changes in his vessel walls.

These attacks of paroxysmal dyspnoea most frequently come on at night. The victim may be seized as soon as he lies down, but more often he is awakened by a sense of oppression and a want of air which compel him to sit upright or to walk about. In severer paroxysms he breathes with great rapidity and difficulty. Moist rales appear, due to the intense congestion and consequent transudation into the air tubes, and often there is expectoration of frothy or even bloody mucus. Expiration is not prolonged as in bronchial asthma unless the congestion causes also a similar spasmodic contraction of the bronchioles. The sufferer's distress is now terrible both to himself and the onlookers, his face cyanosed, covered with sweat, and his whole appearance indicative of his agony. If his heart is examined it is found to be somewhat dilated, its sounds faint, partly because of the rales of pulmonary transudation, but mainly on account of its weakness. The pulse is rapid and weak. In many instances there is the *pulsus alternans*.

After an interval varying from a few minutes to an hour the attack subsides leaving the patient exhausted and agitated.

There are several theories as to the causes of cardiac asthma, the most important of which are those of Basch and Fraenkel.

Basch's explanation is that there is, first, an increased intracardiac pressure caused by high arterial tension or by mitral stenosis. In either case the left heart struggles against pressure from within or from without until it grows tired. The blood is dammed back through the pulmonary veins into the lungs. This pulmonary congestion results in distension and rigidity of the lungs (*Lungenstarheit*) to the impediment of respiration.

Fraenkel dwells more upon the broncho spasm resulting from engorgement of the bronchial mucous membrane.



There must be truth in both theories for the reason that Fraenkel explains the suddenness of the asthmatic attacks and Basch enlightens us as to the occurrence of paroxysmal dyspnoea under varying conditions of high, normal, and low blood pressure. Unquestionably, the final cause of cardiac dyspnoea is a weakened left heart which does not fully empty itself and causes lung engorgement. Under these conditions the right heart has the extra burden placed upon it of forcing its blood into an engorged lung. If this tremendous exertion finally causes the right ventricle to dilate there may be dilation of the tricuspid orifice and a consequent general venous stasis which will relieve the congestion in the lung. The dammed-up blood is drawn off through the venous system. In other words, the lungs are "bled" into the body. There is now a lessening if not a complete disappearance of the dyspnoea, but general cyanosis supervenes. However the decreased dyspnoea does not last long, because very soon there will follow cyanosis of the brain, medulla oblongata and kidneys together with a damming up of the blood in the veins, all of which are new causes of dyspnoea.

In contracted kidney there is defective elimination of toxins that are elaborated from food and their consequent accumulation in the blood, which causes not only irritation of the respiratory centers but an increase in blood pressure by vascular spasm. Secretion of toxins is less at night. This explains why renal dyspnoeas are mostly nocturnal.

The first effect of arterio sclerosis is to cause hypertrophy of the left ventricle. The natural elasticity of the normal vessel walls helps the onward flows of the circulation and as this elasticity gradually diminishes with advancing degenerative changes in the walls, the heart must meet the needs of the circulation by increased effort. There follow, then, hypertrophy of the left ventricle and augmented blood pressure. Not every arterio-sclerotic patient is dyspnoeic, however. One may go for years with an excessively high blood pressure without dyspnoea, if the heart is strong enough to perform its task. But if at any time an extra strain is placed upon it, from over-exertion or other cause, or if the degenerative changes affect the nourishment of the heart muscle itself, there ensue a weakening and a dilatation with pulmonary engorgement and dyspnoea.

Among the less frequent causes of spasmodic dyspnoea may be mentioned chronic myocarditis, acute indigestion, as in the so-called asthma dyspepticum, and aneurism of the aorta.

There is a form of asthma in pale arterio-sclerotic subjects with normal function of the heart and kidneys which Huchard ascribes to sclerosis of the bulbar arteries.

In differentiating cardiac asthma from paroxysmal dyspnoeas of other origin perhaps the most confusion arises between it and bronchial asthma. In uncomplicated bronchial asthma there is no cyanosis, the pulse tension is normal and the rate but little accelerated. After frequent attacks of bronchial asthma a permanent emphysema develops and both increased frequency of the pulse rate and cyanosis are often present. On auscultation we hear the characteristic prolonged expiration, the various kinds of sibilant sonorous rales, with frequently slowing of the respiration. The expectoration shows the presence of Curschman's spirals, eosinophile cells and Charcot's crystals.

In cardiac asthma the breathing is rapid, both inspiration and expiration being short and panting and the rales of the moist variety. However, if the congestion in the bronchioles causes their spasmodic contraction we have a combined cardiac and bronchial asthma with many of the physical signs of the latter, and the diagnosis is rendered difficult.

In chronic influenza paroxysmal attacks of dyspnoea may occur, but the physical signs resemble those of bronchial asthma and the influenza bacillus of Pfeiffer is demonstrable. Paroxysmal attacks of dyspnoea may occur in aneurism of the aorta. In this condition and in spasm of the larynx the difficult and prolonged inspiration with unobstructed expiration distinguish them from the unimpeded respiration of cardiac asthma.

The general treatment of cardiac asthma should be directed toward the underlying pathological causes. As these are chronic conditions and have existed probably for years before manifesting themselves, it follows that not much can be hoped for in the way of a permanent cure. The most to be accomplished will be a checking of degenerative changes in heart, arteries or kidneys. If chronic nephritis exists, with consequent defective elimination, the diet should be restricted, if not exclusively lacto-vegetarian. Sweet milk, buttermilk or koumyss should be the principal food. Sweet milk may be made more palatable by the addition of a little coffee, chocolate or a carbonated water. Five or six pints should be taken daily at the rate of one-half pint every two hours. The number of intestinal bacteria is diminished by milk and a condition approximat-

ing asepsis established. A milk diet also reduces the chlorides in the waste products. Salt should be denied as sodium chloride increases the percentage of chlorides. As milk diet induces constipation the bowels should be kept open by fruit or if necessary by mild laxatives. The patient should lead a quiet life under the most favorable hygienic conditions. Baths should be frequent. As a circulatory tonic carbonic acid baths are beneficial. Alcohol, spicy foods, all meats and the excessive use of tobacco should be avoided.

Whether it is advisable to place the arterio-sclerotic patient under such a restricted dietetic regimen or not should be considered in each individual case. It can hardly be hoped that any diet, however well selected, will check the degenerative changes of advancing age, and such a diet has a tendency to make the patient unhappy and introspective. He should be advised to use the minimum quantity of meat and tobacco and to take no alcohol.

During an attack if anxiety and distress are excessive, morphine may be given hypodermically. While this often gives prompt relief it should be used cautiously for the reason that it relieves by lessening the sensibility of the respiratory center which in turn will cause an accumulation of carbon dioxide in the blood, thus bringing about another attack of dyspnoea. The nitrites and iodides are used with some success, and digitalis has its adherents.

Oxygen is an effective measure of relief but it must be given in large quantities to insure results. This certainly seems a rational palliative measure as the air hunger is due to an imperfect interchange of oxygen and carbon dioxide in the lungs. Any means may be used that will give the patient a large amount with each inhalation.

On account of the weakened heart muscle, rest, approximate or absolute, depending on the severity of the condition and frequency of the attacks, is imperative.

We who use the law of similars in therapeutics have other weapons at our command, however, than those I have enumerated. There are many remedies in the *Materia Medica* that may be selected symptomatically. Farrington suggests the following: Zincum, cadimium sulph., kali chlor. and cactus, where there is great constriction of the chest, relieved by expectoration. Ambragrisea is indicated where there are oppression of breathing, a feeling as of a load or lump in the chest and a flut-



tering in the region of the heart. Cuprum, in asthma with extreme cyanosis. "The patient gets blue and almost goes into convulsions." Lachesis: "Arouses from sleep, and is relieved by coughing up a large amount of watery mucus." I could mention many more, but will be content with calling your attention to one which seems to me to present the most complete picture of the condition, especially when there is exudate in the bronchial tubes; *Grindelia robusta*. I have recently had several cases of cardiac asthma to whom I have given this remedy with results that seemed marvelous. To cite one instance, the patient, a man of sixty-five, with moderately advanced interstitial nephritis and an arterio sclerosis had suffered nightly recurring attacks of spasmodic dyspnoea for several months, being unable to obtain more than two or three hours' sleep on any night. Within a few days after the exhibition of *grindelia* the blood pressure gradually dropped from 185 to 145, where it has remained for eight months, and the attacks ceased altogether, not yet to return. In this connection I call your attention to the fact that in Hare's *Therapeutics* *grindelia* is credited with raising the blood pressure by stimulating the vasomotor centers.

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PNEUMONIA, CAMPHOR IN.—Experimental work on this subject, as well as clinical trials, were carried out by the author. In 20 rabbits inoculated with a fatal dose of pneumococci, death was retarded from two to five days by camphor-oil injections in 8 and entirely prevented in 9. Among 37 cases of pneumonia in human beings, treated with camphor by the author's method, there was but one death. The following conclusions were reached: (1) That 10 c.c. of a 30 per cent. camphorated oil (sesame oil), equal to 36 grains of pure camphor, injected hypodermically to each 100 pounds of body weight every eight to twelve hours, do not produce symptoms of poisoning, in fact are harmless; (2) that proportionally much larger doses are equally well borne in rabbits; (3) that the quantities of camphor mentioned materially assist in overcoming pneumococcic toxemia, and (4) that the earlier the treatment is resorted to the better the results.

The injections are best given on the outer aspect of the thigh. A Luer syringe of 10 or 20 c.c. capacity, without rubber washer, is used. The oil must be sterilized in a large-mouthed bottle with loosely fitted stopper in a boiling water bath, and drawn from the receptacle—not poured—into the sterilized syringe. The point of injection is best disinfected with a few drops of iodine tincture. During the injection the skin, with the subcutaneous fat, must be well drawn up, so that the oil is deposited underneath it. In fat patients the requisite amount may be injected in two localities. In lean persons 20 c.c. can be injected in one place without discomfort. Abscesses are due to imperfect sterilization, and sloughing of the skin to faulty technique.—*A. Seibert (Medical Record, April 20, 1912).*

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### MAMMARY SKIN LESIONS COMPLICATING PREGNANCY AND LACTATION.

BY

B. B. FENIMORE, M. D., PHILADELPHIA.

THE embryonic and anatomical structure together with the changes in the blood supply associated with menstruation, pregnancy and lactation combine to make the female breast particularly susceptible not only to malignant diseases, but also to the more common dermatological affections. The former is essentially a surgical subject; but nowhere is early and accurate diagnosis of skin diseases of more importance.

During pregnancy and lactation we may confidently expect to treat fissures, the different varieties of eczema, seborrhoea, occasionally Paget's disease, and we must not overlook the possibility of lues, primary, secondary and tertiary.

Prophylaxis plays a very important role. Nipples if not properly cared for frequently become fissured and thus open up an avenue for a serious infection. The proper care, that of keeping them well cleansed and soft by the use of olive oil may prevent a very dangerous complication.

Inverted nipples may exist in very young girls and persist over a long period. This defect constitutes a very serious impediment to nursing and efforts should be made to remedy the condition early in pregnancy because active manipulation is contra-indicated during the last few weeks of gestation on account of the close relationship existing between the mammary glands and pelvic viscera. Gentle traction, however, may be practiced, or the breast pump resorted to if this does not suffice.

Eczema fissure of the nipple is frequently a bugbear to the physician and a source of great suffering to the mother. The constant alternating of moisture and dryness results in chafing and in many cases deep and exquisitely tender fissures develop. Aside from the entailed suffering, the especial menace lies in

the possibility of secondary infection of the glandular structure. If proper cleansing with boric acid before and after nursing, drying and the application of olive oil does not control, marked relief may be obtained by the use of compound tincture of benzoin.

Eczema of the nipples and areola is a common affection and may be vesicular, papular, or pustular. It is frequently incorrectly diagnosed. The treatment demands not only the application of medicaments externally but also the careful selection of the indicated remedy.

Erythema intertrigo develops when two folds of skin are in contact, the moisture, friction and heat setting up an active hyperaemia, maceration of the superficial layers of epidermis and thus permits an escape of serum. Improperly treated it may become very intractable, infection taking place, the maceration progressing until a large portion of the breast is involved and although not primarily an eczema the latter may develop secondarily, being recognized by the appearance of one of the primary lesions; a vesicle, a papule or a pustule. The treatment of erythema intertrigo and of a superimposed eczema is practically identical. The raw surfaces must be kept separated by a properly applied sling or bandage. The local remedial agents will be considered later.

Seborrhoea is, as a rule, widely distributed. On the breast, as elsewhere, it is recognized as a macular eruption capped by dirty, yellow, oily scales. Itching is a prominent symptom and is aggravated by sweating or elevations of the surface temperature. The blotting paper test may be quickly made, and is of considerable diagnostic importance. This disease being caused by a micro-organism should be treated by applications possessing bactericidal properties.

Paget's disease, in its earlier stages, is frequently mistaken for eczema. Paget first described it as a chronic affection of the nipple and areola, and held it to be a precursor of cancer of the mammary gland, the long standing irritation producing a favorable soil for the development of carcinoma. This opinion was accepted for a considerable period. Later, other authorities expressed the belief that it is a symptom of already existing carcinoma, which belief is now generally accepted, although appropriate treatment has, according to my experience, cleared up many undoubted cases as the following reports will illustrate. These, taken from my private case records, afford



reliable data, because I have been able to observe them accurately over a sufficiently long period:

Case I. Woman, 40 years of age, under treatment for eighteen months for "eczema." She gave the usual history, long-continued and varying applications at the hands of numerous physicians with at most only transitory amelioration. On examination I found an intensely red, raw surface involving areola and nipple covered with fine granulations and a copious yellowish exudate. There was a well defined line of demarcation and the area was markedly indurated. From a practical standpoint we may regard all long-standing, obstinate inflammations that resist carefully chosen internal and local remedies, as Paget's disease and not eczema. This has been the experience of surgeons.

An ulcerating primary lesion of syphilis may be mistaken for Paget's, but the subsequent development of the cutaneous manifestations soon clears up all doubt as to the nature of the lesion.

Case 2. A young woman, 26 years of age, who six years ago gave birth to a child that died two days later. In the breasts at that time a number of abscesses developed which were incised and drained. These healed under the treatment and gave apparently no further trouble. About eight months ago she noticed that both nipples were inflamed, sore and itched slightly. The soreness was not severe, pain being caused only when the breasts came in contact with her clothing. On examination she presented a few perfectly healed scars, but in the nipples were many little fissures covered with small crusts. The areola was bright red with the raw granular appearance before mentioned and there was the characteristic discharge. One point I wish to bring to your consideration is that although regarded as a disease of middle life it may be encountered in quite young women, as case number two illustrates. Notwithstanding the fact that the time honored local applications have proven woe-fully disappointing in the treatment of this disease, radical operation finally becoming necessary, I have been able to effect a cure in the two cases cited and will report in a later paper the details of the treatment carried out together with microscopic slides to demonstrate more clearly the pathology.

The danger of wet nursing was brought forcibly to my mind in a case referred to me by a physician in a neighboring town. A young woman, 32 years of age, because of some unfortu-

nate complication, had been unable to nurse her baby. An apparently healthy neighbor who had been delivered at approximately the same time and whose child had died a few days after delivery volunteered to act as wet nurse. After a short lapse of time the child resumed nursing from the maternal breasts. When she consulted me she presented characteristic primary lesions on both nipples at their junction with the areola. The secondary exanthem confirmed my diagnosis. An examination of the wet nurse revealed the fact that she had unknowingly contracted the disease from her husband. Both gave very strongly positive Wassermann reactions.

A case illustrating the tertiary manifestations of syphilis was referred to me during the fourth month of her pregnancy. She presented a doughy tumor in the upper outer quadrant of the right breast. Her case record revealed the fact that she had contracted syphilis about twelve years before and had had several relapses despite heroic anti-specific treatment. By the use of anti-specific medication we were enabled to bring about complete resolution. I cite this case to illustrate the importance of making a careful history, for I have known of several instances in which too early ablation of the breast was carried out for supposed malignancy in pregnant women. Even in unmarried women one should not forget the possibility of pregnancy when consulted for a diagnosis of breast tumors, it being not uncommon for so-called lumps to develop at this time.

In conclusion, it may be well to map out a rational line of treatment for the more common eczemas. Bear constantly in mind the fact that acute eczemas call for very mild local applications, to-wit, Burrow's fluid or a similar preparation combined with bland dusting powders. Only in long standing, chronic varieties is it permissible to use any stimulating ointment or lotion. No hard or fast rule can be made, and no prescription given which will in all cases prove satisfactory. Internal remedies in skin diseases of the breast as in skin diseases generally have a wide sphere of usefulness and the best results cannot be obtained unless we employ drugs according to homœopathic indications.

I have received many valuable therapeutic hints in the treatment of eczema fissure and eczemas of other types of the breast from Guernsey's *Obstetrics*. Among the remedies there mentioned are: Graphites, lycopodium, sepia, pulsatilla, petro-

leum, silica and sulphur. Lillienthal mentions arnica and graphites in eczema mammilary; causticum where there is a moist eruption causing ulceration around the nipple.

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## HOW I TREAT A CASE OF PREGNANCY AND LABOR.

BY

LEON THURSTON, M. D., PITTSBURGH.

UNFORTUNATELY for the human race, the science of stirpiculture or eugenics has not, as yet, been able to impress upon mankind the advisability of consulting the physician before conception. At present the important subject of prospective parenthood is rarely laid before us, except for advice as to the best means of preventing it.

I hope, however, the time is not far distant, when by improvement in education, or by the more direct control by legal measures, the intelligent physician shall be asked to give advice as to the fitness of the parties about to engage in that most important business of procreating the species. This advice should not only deal with the material, physical condition of the man and woman; but should include some advice on that more important matter, the psychic conditions under which conception should occur; in order to insure the best equipment for the offspring.

We are compelled, therefore, at present to deal with the woman after conception has occurred; in other words, when she is pregnant; literally, "the state previous to bringing forth." The pregnant woman is entitled to our most thoughtful care and consideration—the destiny of the race is in her keeping—her environment, in the fullest sense of the word, physical, mental and psychical, should be the best obtainable.

The first essential in treating the pregnant woman, is to try to educate her up to the full conception of her newly acquired importance; to impress upon her the glory of Motherhood.

We will assume this to be a case of first pregnancy; the majority are "unwilling"; various reasons are given for this, social as well as economic, but fear of physical suffering is really the dominant one; many accept the situation with a sort of dumb resignation; some few are proud of the prospect; nearly



all are densely ignorant on the subject. It should be our endeavor to calm the fears of the frightened and to stimulate the dumbly resigned; and to teach all of them the salient points: our sincerest congratulations should be tendered those few who are sufficiently intelligent and heroic to say "Yes" to life in this condition, and exult in the prospect of maternity.

For ages the Biblical curse, "I will greatly multiply thy sorrow and thy conception: in sorrow thou shalt bring forth thy children: thy desire shall be to thy husband and he shall rule over thee," has sounded in the ears of woman. It is one of the monumental crimes against her sex. This declaration formulated by man, in an age when woman was his chattel and plaything, and put in the mouth of his deity, in order to lend to it an authority against which he hoped she would not dare rebel, has had a sinister effect in dwarfing the development of character and individuality in the woman, and has consequently been a potent factor in retarding the progress of the race—it should have no place in the thought of to-day.

I try to counteract its demoralizing effect, by assuring the woman that the obstetrical art has progressed to the point that we can at least say: "In safety and satisfaction you may have your baby": and some day I trust we will become intelligent enough to guarantee to every pregnant woman a sufficiently satisfactory environment, (even if State aid has to be invoked) that it may be possible for the obstetrician of the future to say to his patient: "In peace and gladness shall you bear your children."

I am sure if a part of the millions spent annually in prolonging the lives of the proven weak and unfit, was used to ensure the proper care of the pregnant woman, we would eventually evolve better, happier and more efficient men and women; and the State would be the gainer. I hold constantly before the pregnant woman the influence of her mental attitude upon her baby; she is urged to think right and to put fear out of her mind.

At my first interview, an engagement for the examination of the patient is made: this examination is made at the home, and includes not only the usual pelvic measurements, but a careful estimation of the thickness and depth of the pubic symphysis, the distance between the lower border of the symphysis and the tip of the sacrum, and the space between the ischial tuberosities; the general muscle tone of the perineal body and abdo-

men is also noted. The heart and lungs and condition of the blood, and the blood pressure should all be carefully considered. The patient is then given a typewritten copy of the following rules, with any addition or amendments which her particular case may demand, which are as follows:

*Exercise.*—Take as much exercise as is agreeable, or take as much outdoor exercise as is possible, a safe rule being to desist while still feeling that you could do more without tiring yourself—the exercise to consist of walking, driving or motor-ing, but rough roads are to be avoided. If, for any reason, these outdoor exercises cannot be taken I recommend massage.

*Diet.*—Abundant and nourishing food, following your usual customs, but abstaining from highly seasoned and indigestible foods.

*Bowels.*—Care should be taken that the bowels are moved daily. If an abundance of fruit and coarser food do not accomplish this result, take one or two of my laxative tablets at bed time when necessary.

*Clothing.*—Should be loose and so arranged as to exert little pressure upon the waist. In the latter months of pregnancy, corsets should be dispensed with and replaced by a loose fitting corset waist. If the abdomen becomes pendulous or drags on the back, an abdominal support should be worn. Do not wear high heeled shoes or slippers.

*Nipples.*—During the last months the nipples should be massaged daily with olive oil, by rolling them between the thumb and fingers. If small and undeveloped, gentle traction should be used. Massage of the abdomen is also advised during this period.

*Urine.*—I wish you would send me a specimen of urine once a month on a certain date and during the last two months of pregnancy I would like a specimen every two weeks. Keep track of the time your menstrual period would be due and at that time dispense with active exercise or work and remain quietly at home.

I wish you to inform me at once in case any of the following symptoms develop: scanty flow of urine, persistent headache, disturbance of vision, swelling of the feet or face, any loss of blood, no matter how slight; and persistent constipation.

I make it a rule to see my pregnant patients at least once a month to note the general condition and take the blood pressure. They are told to send for me at the first intimation of

beginning labor. At the time of labor my preparations are made with as little of the "spectacular" as possible; everything, even my obstetrical gown, which still occasionally excites comment and sometimes fear, is explained. I examine the patient thoroughly both during a pain and in the interval, and estimate the probable duration of the labor; after this first complete examination, I make as few vaginal examinations as possible, depending largely on abdominal palpation to keep track of the progress. "Encouragement" is now the thing needed; encourage her to be patient and brave, to bear down hard when the pains come; tell her of the thousands who go safely through the ordeal, etc. Encourage her in the way that your judgment finds best suited to the individual—the personal equation enters largely here, and no two can be treated just alike. I try to treat the occasion with just the seriousness it deserves, never making of it a joke nor allowing it to become too funereal.

The patient is allowed to do as she pleases until the perineum commences to "bulge," she is then turned on her side with a special inflated rubber cushion between her knees; the parts are again cleansed thoroughly, (the case has been prepared in the usual way by the trained nurse, which latter I now always insist upon) and sterile pads wrung out of hot saline solution are constantly applied to the perineum; the nurse gives chloroform during the last pains until the head is delivered, (never, however, to the extent of rendering the patient oblivious to my instructions). On delivery of the head, the patient is commanded to stop bearing down and to breathe quickly; this prevents the too rapid expulsion of the shoulders, which more often causes deep laceration than the head, and also quickly dissipates the effect of the chloroform. I wait a reasonable time before ligating the cord, if it is pulsating strongly, but do not always wait until the pulsations cease. My Kelly pad is then cleared and a fresh sterile towel spread on it, the woman turned on her back and the placenta delivered into a special receptacle and set aside for examination. I practice a modified Crede method and do not hurry the uterus to expel the placenta. The vagina is wiped out with a sterile gauze tampon and the patient turned over to the nurse for further "cleaning up"—should there be a laceration it is repaired at once with as few sutures as possible; care being taken not to draw the sutures too tight. I do not give ergot unless it is absolutely necessary, nor do I give a douche as a routine measure. Should a douche be indicated



at any time during the puerperium I use a normal saline solution: this has been my practice for the past four years and has proven eminently satisfactory even in septic conditions. I do not use antiseptic douches.

I allow the patient to get out of bed from the first to use the commode, allow light diet from the start—regulate the flow of milk by regulating the chief milk forming foods and drinks: use a binder only when the patient commences to sit up out of bed, and encourage her to begin the personal care of her baby as early as is consistent with safety.

After she has recovered from the exhaustion incident to the labor, usually on the third day, I allow her anything she wishes to eat, providing she can digest and assimilate it.

The patient is examined when the lochial discharge ceases and again in six weeks after delivery, after which time she is discharged.

It is my constant effort after labor, to impress the woman with the fact that she is not ill, but “tired” and needs rest,—complete rest; mental, as well as physical. For nine months unusual demands have been made on the respiratory, circulatory, and excretory functions; the mental function has also been overworked thinking of, and in most cases worrying about the prospect: there comes the immense physical exertion incident to child birth with the acute pain and anxiety, which produces nerve exhaustion and “she does need rest”: so we keep her in *bed* until the “flow stops.” After she is up, the process by which the uterus returns to its original size is explained, and the importance of rest in facilitating this is emphasized. Finally, the deleterious effect of overwork, mental or physical, on the quality of the milk and consequently on her baby is carefully explained. I try to imbue her with the idea that the nine months following child birth should be a period of rest to compensate for the nine months of work preceding labor, and that the care of her baby should be her chief duty during the period of lactation, in order to insure to it the proper start on life’s journey. Just here I cannot resist the temptation to intrude this thought—each baby means eighteen months of effort on the part of the mother, during which time she should be protected from every adverse condition, and as it seems to me undesirable to make of woman a mere child-bearing machine, I have come to the conclusion that at least five years should elapse between babies, and that she should not have more than five

children during the child-bearing period; or better still, perhaps, allow only the fit to bear children at all; and deny this most important function to the unfit; leaving to them the less important work of the world in so far as it pertains to her own sex. In other words, put a premium on maternity and we would more quickly evolve a superior race. At present the plan is too prodigal—quantity is considered rather than quality—and too many incompetents are produced.

I feel also that when young men and women are taught the fallacy of entering matrimony with the hope of “being happy ever after” and are made to understand that the essential purpose of marriage should be to bring into being a nobler race, then, indeed may the creeping pace of evolution leap up and run, and man become the superb creature he is meant to be.

This paper deals with a normal case, therefore, nothing has been said about the complications that often arise. I have purposely omitted the minute details of obstetrical technique; they are familiar to all of you.

The chief thing in obstetrical practice is unceasing care for the ordinary details. In an association with approximately 1,200 cases I am proud and grateful to be able to say that I have never lost a mother; not because I have any unusual skill or knowledge, but because I am as meticulously careful now, as I was on my first case. While walking home from that first case about five o'clock in the morning I was sure every footstep behind me was someone coming after me because that woman was having a hemorrhage or something had gone wrong.

That feeling of anxiety still obtains, though not so acutely as then; and I never feel entirely free from it until the patient is discharged.

In one respect, however, we are a favored profession; one compensation for the hard work and anxiety in obstetrical practice is the privilege of frequently witnessing the transcendently beautiful sight of a willing young mother's face, illumined by the love-light as he clasps her first born to her breast and says “My Baby.” (Small wonder that this idea should have been appropriated by one of the great religions and for ages has been its most easily comprehended and compelling symbol.) If the case has been a difficult one and you know that your skill has been a factor in bringing about this happy consummation, then your satisfaction is indeed supreme and you may justly feel that you have not lived in vain.

**MEDICAL EXAMINATION AND LICENSURE.**

BY

D. P. MADDUX, M. D., CHESTER.

To some, who have not a practical familiarity with the workings of State Boards of Medical Examiners, it might be thought that a needless hardship and expense is inflicted upon a man who has received the degree of Doctor of Medicine from a legalized medical college to be compelled to submit to a severe examination before he has the legal right to practice his profession: and so it would be, if every medical college in this country exercised an adequately severe discrimination in conferring its degree. The fact remains, however, that there are still a number of medical colleges that cater more to numbers than to scholarship, and some good colleges that graduate a certain number of doubtful men, with the hope that they may pass the State Boards, and "make good" by subsequent practical experience or post-graduate training. The Boards cannot recognize this fact, and must deal with the candidate's preparedness and readiness when he presents himself for examination.

When in the actual work of marking the answers to the questions an examiner finds a number that display a notable ignorance, he is forced to consider whether the question submitted is vague or too severe; but when he reads the answers of the better prepared men, and recognizes how clear and easy it is to them, he feels that the latter are the only type of men who should enter the profession.

I desire to go on record to the fact of the eminent fairness of the representatives of each school of medicine, and to state that the element of sectarian difference was entirely subservient to the consideration of adequate medical training. When it came to a final summing up, and a knowledge of the "school" was necessarily revealed, the case was considered without bias or favor: in fact, each of the representatives seemed more anxious to purge their own medical body from the unfit, than they concerned themselves with members of other "schools."

The Bureau soon after its organization recognized that an attempt to rigidly execute the letter of the Act would probably result in an abortive attempt towards real medical progress, and frankly they made the effort to interpret what they considered



the real spirit of the law and the highest ideals of the profession, rather than slavishly follow its literal details.

I confess to you that it is the ambition of the Bureau to make the standard for Pennsylvania the highest in the Nation, to make all the degrees, from every medical college in this State mean more, and to make the license to practice medicine in this State a much greater assurance of professional competency.

Is there any reason why this grand old Commonwealth should not lead? This is no poor backwoods State that needs temporarily cater to a lower standard; but the best is none too good for us, and we can reasonably expect that the present standard will be materially advanced.

Do not let us complacently feel that we now occupy that high position, for we do not, and there are an increasing number of States that require a higher grade for admission to the medical college than we do.

The character of the questions asked at our recent examination was most carefully considered; the questions were couched with unusual care, receiving a criticism and revision previous to being submitted much more protracted and severe than had been the custom under previous methods.

Instead of the old style didactic questions, a question requiring information upon a single branch of medicine, they were of the type that the doctor must answer by the bedside, rather than the student upon the benches, and yet which a student should be capable of answering before he leaves the benches.

We endeavored to present some of the more usual practical problems, and give what we consider the true elective type of questions, in which the applicant had a considerable range of selection as to conditions and methods, but was required to answer each question, rather than the method adopted in some States of permitting the candidate to select which questions he will answer.

The opinion of the deans of each medical college of the State was sought as to the type of questions that had been submitted, and they each pronounced them eminently fair, and an improvement upon the former type.

An analysis of the results of the recent examination held by the Bureau cannot but have a value, both to the profession and to the medical colleges.

It is remote from the writer's intention or desire to make any statements that would be objectionable to any of the medical

colleges of this State; but he believes that he would be recreant to the branch of medicine he specially represents if he did not call attention to the splendid manner in which the college that represents our school has met the first real comparative test to which it has been submitted. Estimating by relative grades, and by percentage of failures, Hahnemann stood much closer to the first institution than it did to the third.

I do not desire to injure or disparage any college, and when I make these remarks in reference to Hahnemann I do so merely with the desire that due credit may be given to the only college in this State representing our school of medicine, and to emphasize the fact that in that which stands for scholarship and thorough training she stands a close second, as measured by the recent comparative tests.

I do not assume that the figures upon which this statement rests represent a mathematically precise competition; but I have every right to make the claim, when an expert accountant computing from the official tally sheet finds that in general averages and percentage of failures Hahnemann stands a close second; there is not available any other recent official data by which that claim can be disputed.

I shall not submit the detailed figures upon which this report is based; I have no desire to make any statements that might be considered objectionable by institutions occupying a lower grade: I only report the honor roll, in which the University of Pennsylvania stands unquestionably first, and Hahnemann a close second.

There was one individual graduate who had a higher general average than the highest individual Hahnemann average; but there were thirty-eight who graduated from the so-called "regular" colleges receiving a lower grade than the lowest Hahnemann man received.

An emphasis of this fact should be made to the few life insurance companies that still preserve the peculiar anachronism of classifying the scientific standing of our schools with that of their infancy.

An analysis of the answers given by the second-year students would amply demonstrate the great unwisdom of literally executing the law, and affording a complete exemption after the second year in the subjects listed in the Act. For instance, take the question, "Describe the inguinal region," over 15 per cent. of the students had the most hazy or inaccurate conception.

of what was meant by the inguinal region: from umbilicus to mid thigh, including the perineum and external genitalia were included in the total volume of errors in description of that region; yet the most of those very same students upon their graduation, after absorbing the applied anatomy they acquired through other sources, would not have made a similar error.

I am thoroughly convinced from the fact that the overwhelming number of errors in anatomy were in applied anatomy that there should be a more thorough and protracted course in applied anatomy in most of our medical colleges.

I am afraid that anatomical nomenclature and purely descriptive anatomy is being taught at some sacrifice to the time that might be given to the study and teaching of anatomy in its applied form.

It is really not quite so important to remember the name of what is injured, incised or manipulated, as it is to know the relationship and functions of the part injured, incised or manipulated.

Any criticism that I may make upon medical teaching is made in the most kindly spirit. I assume that practical teachers know more than we do about the best pedagogic methods; yet the facts impressed more than one examiner that there was evidence that in some institutions, as judged by their products, of an incoordination of the separated medical subjects, and that the actual practical *relationships* of the different medical branches had not been given the emphasis that had been given to the more clearly defined specialties.

My own conviction upon this subject, based upon the papers which I personally examined, is shared by the other examiners: another instance, a question involving a knowledge of either pathology or physiology alone seemed comparatively easy; but when they were asked to apply well known physiological activities to the modification of well known pathological processes there was much confusion; yet in the real live patient whom he must treat these are the problems he must constantly solve. It is only in the laboratory that you can disassociate pathology and physiology, in the live patient that the doctor must try and help, the two departments are very intimately associated, yes fused; but unfortunately some students leave some colleges without that fusing. My plea is for a more intimate co-relation of the various medical subjects. To the teachers present I am probably but rehearsing old difficulties that have



long time vexed them; but speaking to the men on the firing line, they know that the kind of teaching that they have found most helpful has been the kind that stood by them at the bedside as well as in the laboratory.

A contribution towards the divorce of the different medical subjects may have been made by the universal type of questions previously asked by the Medical Examining Boards, where each question showed a distinct cleavage between the different medical branches, and a candidate was required to answer a question in a manner that required information upon only one branch of medical teaching, while the practical problems that present themselves are always of a more complex nature, and their adequate solution always involves some definite information upon several of the branches of medicine.

We have endeavored in our recent examination to present the actual problems that a man should be competent to solve who is competent to practice medicine.

The Bureau does not desire to assume an autocratic position towards either the colleges or the profession; but to establish the most intimate co-ordination and relationship, and it heartily welcomes any practical suggestion that may come from either source, for we feel we all have a common objective, the making more efficient those to whom are entrusted the care of the sick.

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CHOLELITHIASIS, TREATMENT OF.—According to Paul Mayer, the following indications for operation in cholelithiasis appear to be established, though the question has nevertheless to be decided in each individual case after careful consideration of all the factors concerned:—

1. Acute cholecystitis should be treated medically; only the most severe form, cholecystitis acutissima, belongs to the surgeon.

2. Chronic relapsing cholecystitis should be operated only when all agencies of medical therapy have failed.

3. Operation is indicated in chronic obstruction of the ductus choledochus if two or three months of medical treatment are without effect. In cases with prolonged remittent fever, rigors, and bad general condition, operation is unquestionably indicated.

4. Hydrops vesicæ felleæ demands operation only if there are persistent and very severe irritative phenomena.

5. Empyema of the gall-bladder and all suppurating processes on the region of the gall-bladder and in the liver demand operation.

6. Adhesions about the gall-bladder should be treated medically so long as the inconvenience produced is not marked. In the most severe cases operation is required.

7. Acute and chronic pancreatitis resulting from cholelithiasis belong to the surgeon.—(*The Lancet.*)

## EDITORIAL

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### THE STATE SOCIETY MEETING.

THE recent meeting of the Homœopathic Medical Society of the State of Pennsylvania which was held at the Hotel Kittatinny, Delaware Water Gap, on September 17th, 18th, and 19th, was a forcible example of what can be accomplished by hard work; by keeping the State Society before its members throughout the year. It was a scientific and social success. From a scientific standpoint, it was excellent; for never in the history of the Society have so few papers been "read by title." Never have better, more carefully prepared, or more thorough papers been read. The attendance at bureau meetings was the largest in the history of the Society, and the discussions were general and lively. This will stimulate our men to write papers for future meetings.

From a social standpoint, nothing was left to be desired. It was pleasant to have so many ladies present. Breaking all records, on Monday evening before the meeting, the hotel was crowded with doctors and their wives. The entertainment began on Tuesday evening when the members and ladies were treated to a minstrel show by some of the Philadelphia profession. Many pleasantries were passed upon fellow members and thoroughly enjoyed. Following this, a smoker was held in the café of the hotel. Dr. Wm. B. Van Lennep, Dean of our College, addressed us, telling of the changes in the college building and the curriculum. He concluded his remarks by extending to all a hearty invitation to visit our Alma Mater and see the improvements. Dr. D. P. Maddux, of Chester, a member of the Board of Medical Education and Licensure, gave a talk upon the work of the Board, and indicated the position of our College as a result of the recent State Board examination.

Dr. Palen's presidential address teemed with suggestions for the welfare of the Society, the College, the profession and, last, that which has always been so dear to our big hearted president, the welfare of the young men. Acting upon the

suggestions of the President, a bureau was established, the duty of which is to map out the State and furnish printed data concerning good locations for homœopathic physicians. It is the opinion of the Society that by placing our men in this way we will strengthen our influence. This bureau will stand ready to advise men where they can locate and become successful practitioners.

A Bureau of Publicity was established. This bureau, through the pages of the *HAHNEMANNIAN MONTHLY*, will keep the profession informed on all medical matters.

A committee was appointed to consider the advisability of creating a homœopathic literature. It is the opinion of the Society that this can be best accomplished in a teaching institution. This committee will confer with the Faculty of the Hahnemann Medical College of Philadelphia with this idea in view.

Endowment of our College was considered. In the near future, we will see the advent of a movement to bring about an endowment, and so permanently establish our school.

And now that we have all enjoyed a scientific and social event, and have seen what the Society has accomplished this year; let us pay tribute to the man whose untiring efforts have brought about this fruitful year of the State Society. It is to Doctor Gilbert J. Palen and his magnetic enthusiasm that we must attribute the great success of the meeting. He inspired everybody with the desire to do his duty. His administration will be recorded in the archives of the Society as marking the beginning of a new regime.

The Entertainment Committee deserve much credit for their work. Early in the summer they started work endeavoring to arrange for the accommodation and entertainment of the Society. The bureaus responded willingly and earnestly. To them is due the scientific success of the meeting. Not only were the programs excellent in every detail, but the participants presented papers which indicated their interest in the subjects.

After January 1st, 1913, the office of President will be occupied by Dr. H. S. Nicholson, of Pittsburg, Pa. The Society is to be congratulated upon its choice. Dr. Nicholson is not only highly interested in the affairs of the State Society, but is one thoroughly competent to carry out this very necessary and excellent work.

G. H. W.



**RELATIVE FREQUENCY OF HUMAN AND BOVINE TUBERCULOSIS IN MAN.**

EVER since Koch expressed the opinion that human and bovine tuberculosis were separate and distinct diseases and that the bovine type never occurred in human beings, a bitter controversy has been waged between those who accepted Koch's view and those who contended that bovine tuberculosis not only could be transmitted to man, but that the percentage of human beings infected by bovine tuberculosis was very large. On account of the effect that the verification of Koch's views would have upon the dairy interests, the matter received widespread attention on the part of the public as well as of the medical profession, and several commissions were appointed by various governments to investigate the problem.

After several years of investigation, the preponderance of evidence seems to indicate clearly that pulmonary tuberculosis is very rarely of bovine origin. In 709 cases that were very thoroughly studied by expert bacteriologists in various parts of the world, the bovine bacillus was found in but three cases. In one other case both the human and bovine type occurred together.

The investigations of the cases of tuberculosis of the bones and joints and glandular system, showed quite a large percentage to be due to the bovine type of infection. This was true both in children and in adults. Park and Krumwiède state that six to ten per cent. of the total mortality from tuberculosis in children is due to the bovine type, and the same authorities state that glandular and abdominal tuberculosis in children is more frequently of the bovine than of the human type. In adults the relative frequency of bovine tubercle bacillus for abdominal tuberculosis was 32 per cent., for bone and joint tuberculosis, 3.5 per cent.

The present status of the matter is probably most concisely and fairly summed up with the conclusions arrived at by the Royal Commission of England, which are as follows:

1. The human bacillus, even when administered in large doses, produces only slight and non-progressive lesions in cattle, goats and pigs.
2. It is only exceptionally contained in goat's or cow's milk, namely, when the dose of human tuberculous material is

so large that the bacillus escapes into the blood stream of the animal, and reaches the milk sinus.

3. As to the bovine bacillus, only rarely does a pulmonary lesion in adult man yield this bacillus, but in cases of abdominal tuberculosis in children, about 50 per cent. showed the bovine bacillus and that type alone.

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EPILEPTIC SEIZURES STOPPING AFTER REFRACTION CORRECTION.—The case was that of a man who had been subject to attacks of grand mal about thrice weekly, and who had been free from attacks so far for six weeks since receiving his refractive correction, with the exception of a slight seizure on the night of the day when he first wore glasses. Twenty-two years previously he had been unconscious for several days after being struck with lightning. There had been attacks of vertigo for some time, after which no trouble was experienced till four years ago, when the vertigo reappeared, occurring about once a month for a year. Later he fell on the street with the attack of vertigo, and still later symptoms of petit mal appeared, to be followed by the liability to complete epileptic fits. The eye grounds were normal, and the correction was + 1.25 D. Sph. 0.75 D. Cyl. with the rules in each eye. The patient's mentality appeared to be normal.—*Dr. E. R. Neeper, Annals of Ophthalmology.*

DIFFICULTIES IN THE DIAGNOSIS OF PREGNANCY DURING THE FIRST THREE MONTHS.—By Dr. Paul Bar (*Bull. Med.*, December 9, 1911). Bar gives little weight to the functional signs of pregnancy, such as nausea, vomiting, etc. The first important sign of pregnancy is amenorrhea; next comes changes in the shape of the uterus; it becomes rounded, enlarged and softened. This softening is not like any other. Bar and Daunay have sought a test for pregnancy in the nature of an organic reaction using placental extract. The reaction is never present in the non-pregnant woman; in early pregnancy it is not always present; hence it is of little diagnostic value. Amenorrhea leads to vaginal examination, and finding a small hard uterus indicates that this is not the amenorrhea of pregnancy. If it is caused by genital insufficiency the uterus will be small and hard. If the patient is trying to get the physician to curette her, softness of the uterus will cause him to refuse it. Premenstrual congestion may cause a temporary enlargement of the uterus; hypertrophic sclerosing metritis will cause an enlargement of the uterus which is also softened, and only repeated examinations will enable us to differentiate it from pregnancy. A cyst of the ovary if small, may be mistaken for pregnancy. The feeling of a zone at the junction of cervix and body of a thinness like paper is a sign of pregnancy that has some value. There may be irregularity of the uterus due to implantation of the ovum in an unusual position. The author believes that in most cases it is possible to make a diagnosis of pregnancy at the beginning. The most difficult to distinguish are the angular pregnancies which it is most important to diagnose from extrauterine pregnancy.—*The Post-Graduate.*

## GLEANINGS

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THE DIAGNOSTIC IMPORTANCE OF HEMOPTYSIS.—Dr. W. B. Bartlett draws the following conclusions from his study of hemoptysis.

(1) Bleeding from the upper air passages must be ruled out by careful inspection and history.

(2) Hemoptysis may occur in certain constitutional or blood diseases as merely another manifestation of the general tendency to bleed.

(3) Hemoptysis frequently occurs in broken compensation in heart disease.

(4) Ninety per cent. of all hemoptyses are tuberculous. As a rule definite signs and symptoms are present. Not uncommonly, however, they are in abeyance for months or even years.

(5) Hemoptysis may occur in any ulcerating or eroding pulmonary disease. It should, therefore, be expected in abscess, gangrene, bronchiectasis or pulmonary cirrhosis.

(6) Hemoptysis in pneumonia, bronchitis, asthma or following trauma should lead to the suspicion of an underlying tuberculous process.

(7) It is very doubtful if vicarious menstruation or hysteria can produce hemoptysis in normal lungs.

(8) Hemoptysis occurring without warning in young and healthy adults, and passing off without the development of further signs or symptoms of tuberculosis is probably of tuberculous origin and should be so treated.

(9) Broncho-pulmonary hemorrhage without definite symptoms or signs of cardiac or ulcerative pulmonary disease is due in nearly every instance to tuberculous infection, which is merely another way of saying that hemoptysis should be considered as due to pulmonary tuberculosis unless proved to be due to some other cause.—*Boston Med. and Surg. Jour.*

LATE RESULTS OF TUBERCULIN THERAPY.—Jaquerod gives a report of two series of tuberculous patients treated with old tuberculin some years ago. Of thirteen patients originally "cured" seven years ago, ten have had no recurrence; of eleven patients cured six years ago, ten have remained well. These two series comprise only cases in which the tuberculous process was of an intermediate degree of severity, both the early favorable cases and the advanced cases being excluded. Jaquerod advocates tuberculin therapy only in cases of "open," localized, chronic, and afebrile tuberculosis in which the morbid process is stationary and shows neither a tendency to extend nor to heal. Of such cases, unimproved by hygienic and dietetic measures, a large percentage proceed to recovery under ascending doses of tuberculin. The author does not believe that cases naturally tending toward recovery should receive tuberculin with the object of hastening the cure. He finds that in a certain proportion of patients tuberculin therapy is available for only one course of treatment, i. e., in



these cases, upon attempting to employ it a second time in the event of recurrence, the reaction induced, even with minimal doses, is so great as to be prohibitive; he prefers, therefore, to reserve tuberculin for cases where the stationary condition of the disease demands it rather than employ it indiscriminately in all instances. In febrile cases tuberculin is to be strictly avoided.—*New York Medical Journal*.

**LIBERAL FEEDING IN TYPHOID FEVER.**—Dr. Bernard Kohn is a warm advocate of liberal feeding in typhoid fever. In a recent article in *The Pennsylvania Medical Journal* he makes the following statements:

For several years I have been using a diet consisting of a daily ration of thirty-two to forty-eight ounces of buttermilk; two eggs—raw, in custard, soft-boiled or poached; cereals (tapioca, oatmeal, cornstarch, rice, farina), twice daily, with cream and sugar; scraped beef, salted, once daily, later alternating with broiled Hamburg steak and finely minced chicken; gelatin, custard or milk-toast, once daily; crackers and butter, twice daily. If the condition of the bowels warrants it, apple sauce or baked apple is also allowed. I frequently also give well-baked potatoes, with butter and salt.

I have thus treated a series of thirty-four cases of typhoid fever and have no reason to regret the experiment. Of these thirty-four patients only one died, of nephritis—a mortality of three per cent. The duration of the febrile period after admission to the hospital, including relapses when these occurred, varied from two days to fifty-four days, the average being nineteen days. The average duration before admission was approximately thirteen days, making thirty-two days the total average duration of the disease. This period of duration was assumed to extend from the time that the patient first began to feel ill until the time when the temperature remained permanently below 99 degrees. Relapses occurred in six cases, or 17 per cent. Hemorrhage occurred in three cases, or 8.8 per cent., none of which proved fatal. There were no cases of perforation. The other complications were myocarditis, three cases; otitis media, one case; bronchitis, one case; nephritis, two cases, one of which caused the only death in the series. I feel reasonably certain that one of the patients with myocarditis, and another patient in whom the febrile period after admission lasted fifty-four days, would have succumbed, had it not been for the increased resisting powers fostered by the liberal diet.

Of course, my statistics cover only a small number of cases, and alone can lead to no definite conclusions. But the observations on this subject, taken as a whole, show that under liberal diet the mortality is not increased, but rather lowered; that complications are not more, but rather less frequent; that the mortality from these complications is not higher, but if anything lower; that convalescence undoubtedly is greatly shortened; that the patients are much more contented and less prostrated during the course of their illness; and that they are able to return to their occupations much earlier than under the older forms of starvation or semi-starvation treatment. It is a significant fact that none of the critics of liberal feeding in typhoid fever have ever tried it; while none, who

have given it a trial, have ever gone back to the use of the more restricted diets.

THE PATHS OF RHEUMATIC INFECTION IN CHILDREN AND THEIR PROTECTION.—Mackenzie in the *British Medical Journal* of June 1, 1912, discusses this important theme under several heads.

The importance of protection from local and general infection cannot be exaggerated, and the time has come when the mind of the profession, and more particularly the general practitioner, must turn to the possibility not only of treating rheumatic phenomena in children early, but of preventing their occurrence.

Hypertrophied adenoid tissue in the throat and nasopharynx should be removed in the quiescent stage, and simple congestion of the pharynx, palate and fauces in a child with a rheumatic family or previous history or with a rheumatic facies, should always be looked upon seriously, and met with local applications of salicylic acid preparations, together with sodium bicarbonate, sodium salicylate, potassium chlorate, and aperients. A 5 to 10 per cent. of sodium salicylate applied to the tonsils, palate, and pharynx gives a protective film from further contamination, and does not impair the defensive action of the tissues; or a gargle containing 20 to 40 grains to the ounce is equally efficacious. Care should be taken that decayed teeth are stopped or extracted, and the tooth-brush and antiseptic powder should be insisted upon daily.

Inhalation for half an hour, three times a day of 10 minims of a solution of equal parts of creosote and carbolic acid with a Burney Yeo inhaler is, Mackenzie believes, the best method of protecting the pulmonary mucous membrane.

His experience is that sodium salicylate combined with sodium bicarbonate and rhubarb powder is by far the best protective treatment in cases in which there is any indication of excess of mucus in the intestine, the alkali acting as a solvent, the rhubarb clearing the offending material away, and the salicylate acting as a sedative and healing agent to the mucous membrane.

His conclusions are as follows:

1. The micrococcus rheumaticus takes the path of least resistance.
2. This may be an unhealthy throat, absorption from which frequently gives rise to general rheumatic infection, including peritonitis and appendicitis, directly through the vascular system.
3. Or it may be localized in the bronchial tubes and give rise to pneumonia, with polyarthritis and endocarditis.
4. An unhealthy condition of the intestinal wall may excite to activity the rheumatic agent, setting up acute rheumatic phenomena with peritonitis or appendicitis as part of a general infection.
5. A mild catarrh is produced at the seat of inoculation, and one or more of three factors in each case are present and promote the inroads of the micrococcus. Either (a) the physical resistance, or (b) the protective properties of the local tissue, or (c) defensive agencies of the blood, are below par.
6. The distinction between acute and subacute or latent rheumatism is

mainly due to general infection with the actual rheumatic agent in the former and with the toxins only in the latter.—*Therapeutic Gazette*.

A STUDY OF 3268 VENEREAL PROPHYLACTIC TREATMENTS.—Holcomb in the January issue of the *U. S. Naval Medical Bulletin* makes a report and tells us the treatment is as follows:

1. Wash penis, head, shank, and under frenum with 1.5000 bichloride of mercury solution with a cotton sponge.

2. Pass water. Take urethral injection of two per cent. protargol solution and hold to count 60.

3. Rub 50 per cent. calomel ointment well into the foreskin, head, and shank of penis, with particular care about the frenum.

Either side of the frenum is the most frequent site of sores.

Of the 56 cases of gonorrhea occurring in the first 24-hour interval, 26 were recurrent cases; the remaining 30 were primary infections.

There were 1385 exposures in which the treatment was taken within the first eight hours, and among these men there were 19 infections, or 1.37 per cent.

There were 731 exposures in which the treatment was taken in the interval of eight to twelve hours after exposure, and among these men there were 25 infections, or 3.41 per cent.

Undoubtedly all cases with an incubation period of over ten days should be thrown out, as there is probably a question of veracity on the part of the man, who to escape punishment refers his exposure to the last time he took the prophylactic treatment. There are nine who come in this class. We have not excluded them in our statistics, but leave the reader to judge.

There are several factors that should be taken into consideration with regard to the statistics of the prophylaxis of this disease.

A large percentage of the men returning from liberty come on board under the influence of intoxicants, and as a consequence are careless in taking the treatment. Some of the men, who have sensitive urethras, complain of pain on taking the injection. Needless to say, under these conditions the full benefit is not obtained.

THE TREATMENT OF DOGBITES.—Lesser considers the subject in detail and recommends the following course of procedure:

1. The wound should be allowed or encouraged to bleed as freely as possible for several minutes. If a large vessel be severed, it needs to be controlled earlier, of course, than if there were capillary bleeding.

2. After the wound has bled sufficiently, a wad of cotton saturated with a mild antiseptic solution, such as equal parts of alcohol and water with a small percentage of iodine, should be applied with as moderate pressure as may be required to control the bleeding and protect the wound from further infection. The wad should be kept moist (not too wet) with a similar application, but with as little interference with the wound as possible.

When the area is small after the bleeding has been controlled, an application of an antiseptic wool-fat ointment may be found of advantage. The selection of the application or ointment must be left to the physician, but



it should consist of ingredients well calculated to soften the tissues, favor absorption of the active antiseptic, and at the same time stimulate the area to encourage different action of the tissue fluid. A properly prepared lanum, lanolin or kindred medium will be found to serve well.

3. If the wound does not bleed, a suction pump (similar to a cupping pump) should be applied, but where there is none at hand cautious suction with the lips could be made. This may be done by the patient if he can reach the part, or it may be done by an attending person without injury to himself or the patient, if proper precautions are followed. It has been demonstrated that a perfectly healthy person may swallow snake poison or septic material without any harm whatsoever, their poisonous properties being made innocuous by the healthy digestion fluids, particularly fresh human saliva and gastric juice. Still, the uncertainty of health and a possible abrasion on the lips or in the mouth make precaution advisable. The suction should, therefore, be made by holding in the mouth an alcohol, water and iodine solution above mentioned, while the lips are held over the infected area, so that the solution may play around the wound and protect the mouth from infection. In experimental work a properly prepared acidulated pepsin solution has also been found very serviceable for this purpose, but the alcohol seems to stimulate free bleeding and, as said, also protects the wound from possible mouth infection.

4. When the suction does not produce bleeding it indicates that the blood capillaries were not injured and the poison is carried in the lymph channels. In these cases an application of the antiseptic wool-fat ointment should be made. While these antiseptic applications may exert no immediate special influence upon the internal portion of the wound, they keep the parts pliable and permit the exit of the virus.—*American Journal of Surgery*.

THE DIAGNOSIS AND TREATMENT OF HYPOTHYROIDISM.—It has become more and more evident that increasing attention must be paid to functional disorders of the glands connected with internal secretion. Well-developed cases of myxedema and cretinism can scarcely be overlooked, but other cases which present the symptoms of these maladies in their earliest stages readily fail of recognition. For this reason we think that there is much of interest in the lecture on this subject which appears in the *Clinical Journal* of February 28, 1912, by French of London. He emphasizes the fact that thyroid gland often proves itself a most valuable remedy in those instances in which evidences of a lack of thyroid secretion are manifest, as, for example, in certain infants, who without being true cretins nevertheless possess symptoms of apparent amelia or idiocy; in backward children between the ages of two and five presenting various symptoms, of which the two most familiar are perhaps slowness in learning to talk and delay in learning to walk; and in growing boys and girls who suffer either from general mental backwardness, or what is more troublesome in some cases, from persistent nocturnal enuresis. So also he has found thyroid substance useful in stout, sterile women of the child-bearing age, in women who rapidly become too stout at or about the menopause, and finally in some cases of functional nervous disorder presenting symptoms which can be classed as neurasthenia. Other patients

suffer excruciating pains from tic-douloureux, and French reports two cases of extreme tic-douloureux which were cured by thyroid medication when all other measures failed, the thyroid extract being given in the form of the dry powder in one-grain doses three times a day, and afterward increased to three grains three times a day, and after some months diminished to  $1\frac{1}{2}$  grains three times a day. Concerning dosage French states correctly that this varies enormously with the individual. In infants and young children  $\frac{1}{2}$  grain of the dry powder once a day or at most twice a day is usually sufficient, and after it has done good it may be diminished to as small a dose as  $\frac{1}{8}$  grain; whereas for adults the common dose would be 1 grain night and morning, or whatever quantity is necessary to produce results. Very rarely he has found 5-grain doses necessary. The first symptoms of overdose which manifest themselves are, in children, diarrhea, and in adults, nervousness. The pulse also becomes rapid.

While we should be careful that the extraordinary results produced by thyroid extract in a limited number of cases do not lead us into the error of believing that this substance is a cure-all, we nevertheless remind our readers that the type of cases which Dr. French describes is well worthy of attention.—*Therapeutic Gazette*.

THE PRESENT POSITION OF SALVARSAN.—An anonymous writer in the *Lancet* of April 6, 1912, writes incisively on this subject. He says that in spite of the eminence of the introducer of the salvarsan treatment of syphilis, the solid scientific basis on which it appeared to rest, and its marvelously rapid effects, like all vaunted remedies (one might say proprietary remedies) this drug has failed to maintain its claims. Where is the *sterilisatio magna* which we were told could be accomplished by a single dose? The advocates of the treatment now resort to several doses and still are not able to prevent relapses. So great is their confidence in the treatment that they recommend it be followed by the disparaged mercurial course!

Turning to the question of safety, the eposition is equally unsatisfactory. Deaths following its administration are now constantly recorded, and reports come from all over the world that many are never recorded. The earlier deaths were attributed by Ehrlich to the use of the drug in unsuitable cases, when contraindications which he has laid down, such as organic disease of the nervous or cardiovascular system, were present. Admitting this explanation, for the sake of argument, it is only one proof of the dangers of the drug. For in several of the recorded cases the patient showed no signs of the lesion found after death and held responsible. Thus in the case reported by Professor Oltramare, of Geneva, a robust man who had contracted syphilis fifteen years before, desired an injection of salvarsan, although he was free from symptoms. A complete examination revealed no signs of disease. He was given a single intravenous injection of 60 centigrammes, which was well borne. On the third day he complained of headache, and on the fourth day died comatose after several attacks of convulsions. Two of the supporters of the salvarsan treatment ask why not throw some of the blame on the leptomeningitis, chronic bronchitis, and bronchopneumonia which were found

postmortem. Excepting the bronchitis, the evidence is that these lesions were due to the drug. In any case the argument is irrelevant as regards safety, for the man was on examination found not only healthy but robust.

Several other cases have been recorded in the columns of the *Lancet* in which ordinary doses of salvarsan proved fatal to young robust patients. We are unfortunately familiar with the symptom-complex of coma, epileptiform convulsions, and death—termed by Sicard meningotropism—as a result of the injection of salvarsan, and it corresponds exactly to the nervous form of acute arsenical poisoning. Indeed, Mr. Forester (an advocate of salvarsan, by the way) says that it is “inexplicable except as acute arsenical poisoning.” It is curious that it most frequently has been observed after a second dose.

At a meeting of the Societe Medical des Hopitaux of Paris on November 17th last M. Paul Ravaut discussed a series of eight such fatalities, one of which occurred in his own hands. In all a young robust patient without visceral disease was given an ordinary dose of salvarsan which was well borne. After a varying interval a second dose was given, and was followed by vomiting, pyrexia, epileptiform convulsions, coma and death. The necropsy showed congestion of the brain and other organs, and sometimes small hemorrhages into them. In three other and non-fatal cases an erythematous eruption appeared after the second injection. The advocates of salvarsan attribute them to cumulation. M. Ravaut was compelled to reject this explanation, for in some of the cases the doses were small and the interval between them was many days. Thus, in one fatal case two doses of only 40 centigrammes were given at an interval of forty days. As to the theory of Wechsellmann that such symptoms are due to microbes in the distilled water used for dissolving the salvarsan, M. Ravaut points out that he always uses filtered water, sterilized at 120 degrees C. Moreover, in two of the cases the same solution was used for other patients who manifested no symptoms. The only conclusion is that the ill results were due to some idiosyncrasy. Possibly the first injection causes some modification, which leads to decomposition of the second dose. It is not generally realized that an ordinary dose (60 centigrammes) of salvarsan contains such a large quantity of arsenic as three grains. It is true that, as in the cacodylates and other organic compounds of arsenic, quantities of arsenic otherwise poisonous can be given in salvarsan usually with impunity, but we have no guarantee that such compounds may not sometimes decompose in the body, setting free a toxic amount of arsenic. On the contrary, we now have evidence that this does occur.

In addition to the form of arsenical poisoning just described, commoner and characteristic toxic effects have been observed—acute fatal nephritis, fatal jaundice, herpes zoster, erythema, melanosis, conjunctivitis, vomiting, diarrhea, and muscular cramps.

In the paper referred to above, suggesting that the toxic symptoms following the administration of salvarsan are due to microbes in the distilled water, the writers have produced evidence only that the immediate and temporary symptoms following the injections—rigors, rise of temperature, and malaise—are due to this cause. They have produced no



evidence that symptoms of arsenical poisoning can be so produced. In the extensive use of saline injections in surgery, without the elaborate precautions now enjoined to keep the solution microbe-free, has any one observed arsenical poisoning, or, excepting cases in which enormous quantities have been administered, any serious effects whatever? Finally, take the theory that the toxic symptoms are due to endotoxins set free in the destruction of the spirochætæ. If true, this would only be another admission of the dangerousness of the drug, for who can gauge the amount of endotoxin that will be set free? But, as Professor Finger has shown, similar symptoms follow the use of the drug in psoriasis and leprosy.

One gets impatient of these ever-changing "explanations" which do not explain, and are only attempts to square the facts with the erroneous teaching that salvarsan is innocuous when given according to rule. They are an insult to the intelligence. In the routine treatment of syphilis salvarsan has shown no advantage over mercury, except rapidity of action; that in permanency it is less reliable; and, therefore, that it is unjustifiable to expose patients to its undoubted risks. It may have a place in exceptional cases which do not yield to mercury.—(*Therap. Gazette*).

TONSILLOTOMY OR TONSILLECTOMY.—Danziger (*New York Medical Journal*, June 1, 1912), gives the following indications for enucleation of the tonsils in children:

Cases of buried tonsils where the pillars and the plica—that is, the fold of mucous membrane which connects the two pillars below—envelop the tonsils almost entirely. Such tonsils are of no use, as they will not take up bacteria with the ingested food, nor will they be able to empty their crypts on a secondary tonsillitis from nasal or buccal infection.

In cases of small atrophic tonsils which cannot be removed, partly on account of their size, a microscope shows large defects in the epithelium of the crypts, sometimes its complete disappearance.

In cases of suspected tuberculosis of the tonsils, unfortunately, the chronic form of tuberculosis cannot be diagnosticated clinically. Therefore, given an anemic child with tuberculosis adenitis of the neck and abnormal tonsils, the tonsils have to be enucleated, as the tubercles are always situated deep in the tonsil underneath the epithelium of the crypts.

In adults, recurrent attacks of circumtonsillar abscess call for enucleation as the only guarantee against future attacks.

Malignant affections are self-evident indications for this operation.

To make the age of the patient an important factor for the choice of operation is not logical, as the microscope shows the existence of the crypts at all ages, with the same production and diapedesis of lymphocytes, even if there is an increase of connective tissue.

That the total enucleation of the tonsils does not always accomplish the desired results has been shown by Finger, who has demonstrated that in quite a number of cases new lymphatic tissue may develop from the lymphatic tissue back of the tongue. As another drawback to the total extirpation of the faucial tonsils, we have to consider its deleterious effect on the voice, especially of singers and public speakers.

THE X-RAY TREATMENT OF ACNE.—M. K. Fisher describes the method

that he employs as follows: The patient is placed in the recumbent posture; the hair, eyelashes, and eyes, and if a man, the moustache, are covered with lead foil; each side of the face is treated separately, as it is difficult to get an even distribution of the rays if full faced exposure is made, especially if there happen to be a number of lesions back of the malar eminences or near the angle of the jaw; a tube of low vacuum is used, held in a protective leaden glass shield, eight to ten inches above the region over which the exposure is to be made; the rays, which are filtered through sole leather, should allow the passage of three-fourths to one milliamperere of current through the secondary circuit, or, if a radiometer or milliamperemeter cannot be employed, about the radiance that in a darkened room will show as a faint yellowish green light; each side of the face receives an exposure of six to ten minutes, depending on the amount of inflammatory reaction that is present, those cases where there is already present considerable redness not being treated so strenuously, while in cases in which there is much induration the more prolonged exposures are given. Treatments are given twice a week, although after a time the seances may be reduced to once a week. If given more frequently, the treatment may produce a burn, and the author has never found it necessary, or even advisable, as Stelwagon and others have recommended, to push the treatment to the extent of producing an erythema, and then discontinuing treatment until the redness has disappeared. For the first two or three weeks after commencing treatment little change can be noted in the disease; gradually the redness is seen to become less pronounced and the lesions almost imperceptibly to fade; the indurated areas decrease in size, and in the pustular form of acne there is less tendency for suppuration to result. One of the first effects noted is the disappearance of the oily seborrhea, which, as Sabouraud asserts, always accompanies the acne.—*New York Medical Journal*.

THE FRENCH COMMISSION ON ANTI-TYPHOID VACCINATION.—The report of this commission of the French Academy of Medicine is summarized as follows:

1. This method of procedure has been carried out on more than 100,000 soldiers in the English, German and American Armies.
2. The benefits of preventive inoculation are seen in the comparative statistics of typhoid mortality and morbidity. Only half as many of the vaccinated have had typhoid fever, as of the non-vaccinated.
3. Vaccination does not abolish typhoid fever, it diminishes its frequency, and the vaccinated who get the fever have it in a mild form.
4. Two or three inoculations with bacillary vaccine are better than one, and four will be necessary with antilysates of living bacteria.
5. Immunity lasts from one to four years, and hence revaccination is desirable.
6. Anti-typhoid vaccination is not dangerous. Dead bacilli when injected will cause fever and pain from twenty-four to forty-eight hours. An antigen of living bacilli will cause little or no pain.
7. Preventive vaccination should usually be performed before the appearance of the disease as an epidemic.

8. Vaccinated persons should not relax their precautions as to the matter of food and drink for at least two or three weeks.

9. Soldiers and sailors may be vaccinated at their port of arrival if the disease is not epidemic at that port at that time, otherwise the inoculation should be made about three weeks before leaving home.

10. Vaccination should be performed only on those who are free from all form of disease.

Those who are likely to be benefited by anti-typhoid vaccination are:

- a. Physicians, nurses and medical students.
- b. Families in which there are bacillus carriers.
- c. Those who have gone from salubrious localities to localities in which typhoid is endemic.
- d. Dwellers in cities in which typhoid is prevalent.
- e. Soldiers and sailors who are sent to colonies where typhoid is epidemic or endemic.

GONORRHEAL ARTHRITIS.—Sever writes on this topic in the *Boston Medical and Surgical Journal* of May 10, 1912. This short resume of some of the more recent literature seems to indicate that the results vary considerably. Apparently in the early and acute and subacute cases results may be good, relief from pain quick, and early function obtained in some cases. In others, relief from pain alone seems to be the one result obtained. This in itself, however, is of value. It would seem that in the early cases before a general infection had taken place, the mixed bacterins would be of the greatest value as compared to the antigonococcic serum. Apparently, however, the sera have given the best percentage of results, indicating probably that the infection had become a general one and a lack of individual resistance had become established. The matter, however, has not been studied long enough apparently for observers to have come to any definite conclusions as yet in regard to the value of these procedures, and there will probably always exist more or less uncertainty as to the value of the method so long as individual susceptibility and resistance varies. It is almost needless to state that one or both methods—that is, the administration of the mixed bacterins or serum—should be used as a routine in all early cases in the hope of producing an effect.

In the old chronic cases, in which the joints have lost their integrity and become partially ankylosed, orthopedic measures are indicated. The opening of the joint, and the insertion of muscle strips after the fashion of Murphy, or fascia, or distention of the joint by oil of iodoform as advocated by Brackett, seem to offer methods of restoring some function. Stiff and tender spines are to be protected by plaster jackets until the acute irritation has subsided.—*Med. Rev. of Reviews*.

CLINICAL INDICATIONS FOR TRANSFUSION OF BLOOD.—Soresi (*Medical Record*, May 4, 1912), has performed twenty-five cases of direct transfusion. Very gratifying results were obtained in hemorrhage from all causes, providing the condition that caused the hemorrhage was removed. Blood transfusion should be employed only when the loss has been severe and shock is present. In this series of cases it seemed to the author that transfusion, though successful technically, did not help the patient



in one case of hemorrhage from miscarriage, and in another from ulceration of the intestines in typhoid fever—the patient dying while the procedure was going on. In severe cases of postoperative shock transfusion is useful not only after but during operation. Many patients could be saved if the shock which is caused by the anesthetic and hemorrhage during the operation could be prevented. In five cases of operation on the biliary tract two patients died: transfusion in one was performed three days after operation—blood serum and saline solution had been used previously; in the other transfusion was performed five hours after operation, and the patient died a few hours later. In the other three transfusion was performed during operation, and the patients made an uneventful recovery, although one had only thirty per cent. hemoglobin before the operation; in none did postoperative hemorrhage occur. The author describes an ingenious and somewhat elaborate technique.

RICE IN THE DIETARY OF THE DIABETIC.—*The Medical Record* of June 29, 1912, contains an article by Stern on this subject. He reaches these conclusions:

1. Rice—*i. e.*, the "polished" product of commerce—furnishes substantially nothing to the organism besides an easily digestible starch. Given in suitable amounts this starch is practically all absorbable and ready to serve as a calorifacient.

2. The commercial cereal is, therefore, peculiarly adapted to supply carbohydrates without any protein or mineral admixture of consequence.

3. This deficiency of protein and mineral substance makes rice an indifferent food so far as the formation of toxic protein products and useless or impossible pancreatic, cardiac, and renal activities are concerned.

4. The mineral and protein deficiency of rice facilitates the reduction of salts and the calculation of absorbable albumin necessary at every stage of the diabetic affection. (The elaboration of proteins from cereals and leguminous seeds by the healthy organism is mostly incomplete; it is impossible, or nearly so, in every case of advanced diabetes.)

5. Rice being nearly entirely absorbable, only a comparatively small quantity of it is needed by the diabetic organism; it is not the purpose of the rice to supply the total food requirement as does v. Noorden's standard oat diet; the cereal may be incorporated with any properly adjusted proteinfat combination.

6. Contrary to the oat diet, rice as a single form of carbohydrate and in suitable combination may be employed by the diabetic for more protracted periods: it may be prepared in a number of different ways and forms that prevent monotony and always furnish a palatable dish for the patient.

7. Sixty grammes of the absorbable starch granule of rice generally produce the antiacetonemic effect of 250 grammes of the but partly absorbable oats in the standard admixture.

8. Pronounced cases of acidosis are frequently suppressed by the ingestion of 100 grammes of rice.

9. The amount of rice requisite to depress the acetonuria does not necessarily increase the intensity of glycosuria. In a large number of cases the glycosuria will even temporarily decline in a marked degree.

10. The *modus operandi* of rice is different from that of cereals rich in cellulose. Practically all the rice is absorbed and a certain amount is assimilated by the diabetic (this is evinced by the frequent increase in weight and vigor of the patient and the diminished glycosuria and acidosis), while material rich in cellulose, no matter how much albumin and fat may have been added to it, furnishes in effect nothing more than a starvation diet.

THE MODERN CONCEPTION OF GOUT AND ITS LATEST TREATMENT.—H. A. Rosma writing on this important subject says that although Wollaston saw some relation between gout and uric acid, and Garrod in 1848 proved that there was an increase of uric acid in the blood of gouty patients, it is only of very recent date that we know something more definite about the pathogenesis of arthritis urica.

It was Emil Fisher who taught us that the source of uric acid is not albumin, as was generally believed, but he demonstrated that it is derived from nuclein, the main constituent of the cell nuclei.

In uric acid formation we have the very striking example of the action of a succession of enzymes. The first of these is called nucleose, which liberates from nuclein the two purin bases, named adenine and guanine. The next to come into play are certain deamidizing enzymes; one of these, called adense, converts adenine into hypoxanthine, and another called guanose converts guanine into xanthine. Finally oxidases step in, which convert hypoxanthin into xanthine and xanthine into uric acid. In some organs, especially the liver, there is a capacity to destroy uric acid after it is formed, and so we are protected from a too great accumulation of this substance.

The enzyme responsible for uric acid destruction is called the uricolytic enzyme. The uric acid which ultimately escapes as urates in the urine is the undestroyed residue. Now, Brugsch and Schittenhelm have shown that the essential factor in gout is a disturbance in the nuclein metabolism, brought about by some defect in the entire fermentative apparatus, producing a constant presence of uric acid in the venous blood.

There is no gout without a uricemia as precursor, yet there are uricemias that do not produce gout. In leukemia, for instance, there is a considerable increase of uric acid in the blood. There is sometimes far more than we find in gout, yet the sufferer from leukemia has no gouty attacks, and no tophic formation takes place.

When a healthy normal person is fed on a purin-containing diet, uric acid develops in his blood; a gouty subject, however, has uric acid in his blood when being fed on diet entirely free of purins. In his case it is derived from the nuclein of his own body cells.

Whether these disturbances in the action of the ferments are primary or associated with or dependent on other regulators in the body, like the nervous system, is not known.

Another observation of recent date is that the uric acid in the blood is mononatrium urate held in solution. The blood of a gouty person is not over-saturated with uric acid, nor is its alkalinity decreased—in fact, it often is increased.

The mononatrium urate thrown out of solution sets up inflammatory

processes in the joints; Von Loghem thinks that it is mechanical irritation that causes the inflammation. What then causes urates to be deposited in the joints? Experiments by Van Loghem and Silbergleit have shown that an increase of sodium in the body fluids decreases the solubility of the mononatrium urate, and they strengthen the views of Falkenstein, who empirically found beneficial effects from the ingestion of hydrochloric acid. Ueber thinks that in gouty subjects the affinity of the tissues for uric acid is increased, and he refers to the great absorbent power of cartilage for uric acid.

From this resume it will be seen that in the pathogenesis of gout there are still problems for further study, yet we do know that the essential factor is a constant uricemia, in many cases brought about by an anomaly in the nuclein metabolism, but not exclusively so. We may also have a uricemia in the wake of sclerosed kidneys in the stage of decompensation with all the clinical symptoms of gout resulting therefrom.

Our therapeutic measures are the logical deductions from what we at present know about the pathogenesis of gout:

1. Restrict purin-containing food.
2. Accelerate the excretion of uric acid by way of the kidneys and intestines.
3. Increase the solubility of the urates.
4. Promote oxidation of uric acid.

About the last point a few words: Lowenthal's experiments with radium on ferments led Gudzent to investigate the influence of radium on the disturbances in nuclein metabolism, caused by a deficient action of ferments. It was shown that *in vitro* radium emanation dissolves and destroys mononatrium urate, and further that it does the same thing in the human body. Gouty patients after a prolonged treatment with radium emanation, whether taken in water or by inhalation, lose their uricemia and they metabolize easily purin-containing food. This is a fact of great importance. According to Gudzent this is due to activation of enzymes that had become inactive, chiefly of the uricolytic ferment. These beautiful researches have paved the way for a more radical cure of gout and other diseases of metabolism, and they also have thrown a new light on the empirical fact that many constitutional diseases are greatly benefited by taking the waters in watering-places here and abroad.—*Med. Rev. of Reviews.*

#### HYPODERMIC INJECTIONS OF IRON AND ARSENIC IN SECONDARY ANEMIA.—

John J. Musser, Jr., in the *Boston Medical and Surgical Journal* of May 23, 1912, states he has had the opportunity to observe the general condition and to make repeated blood counts in a series of fourteen cases which received, hypodermically, injections of iron and arsenic.

The iron is used in conjunction with arsenic and sodium glycerophosphate. The iron and arsenic, of each .06 gm., and the sodium glycerophosphate, .10 gm., are dissolved in 1 Cc. of distilled water. This makes a slightly alkaline, reddish-tinged solution, clear, without sediment. It is placed in small glass ampoules, sterilized, and when sealed is ready for instant use. Each ampoule contains a sufficient quantity for one dose. The few minutes to sterilize the syringe and needle are all the time re-



quired to give the injection. It may be given in any muscle, but in the treatment of ambulatory cases the most satisfactory site of injection is directly into the muscles of the thigh or into the deltoid muscle. The solution is so free from irritating qualities that it has not been found necessary to give the injections deep into the gluteal or lumbar muscles. The treatments, as a rule, were given twice a week, though in some cases as often as daily for a short time. In several cases the injections were only given once a week. With the iron and arsenic, treatment was usually given for the local condition causing the anemia. In some of the cases treatment of the local condition had been carried on for some time without any definite improvement. Upon the addition of the iron and arsenic the results were usually most pronounced. The increase of hemoglobin and erythrocytes brought with it freedom from the troublesome symptoms of before. The amelioration of the symptoms and improvement in the primary trouble usually resulted in the patient's discontinuing treatment before it was desirable. In most of the cases the treatment was simply the correction of dietetic and hygienic faults.

Of the fourteen cases treated in this manner, only one failed to respond promptly. This patient, a young married woman was found later to be pregnant, and the treatment was discontinued.

The author has had the opportunity of studying the blood in a case of pernicious anemia. Before the treatment began the hemoglobin was 19 and the erythrocytes 950,000 per cubic millimeter. Two months' treatment raised the hemoglobin to 68 and the erythrocytes to 3,490,000 per cubic millimeter.

Musser's conclusions are as follows:

1. The intramuscular injection of iron and arsenic in organic compound is entirely practical in office and dispensary work.
2. It is a valuable adjuvant to the treatment of anemia secondary to some relatively mild condition.
3. It affords a method of giving the drugs in which the exact amount taken is accurately known.
4. It does away with the annoying complications frequently resulting from the administration of the drugs by mouth.

A SIMPLIFIED METHOD OF TREATING FLATFOOT.—Judson, in the *Medical Council*, gives the following rules of management:

1. Advise the patient that, as a rule, the only use of the uppers in a shoe is to keep the leather sole under the foot, according to the old saying that to a man with shoes it is the same as if the world were covered with leather. Therefore prescribe a wide and flexible sole, with slight if any elevation under the heel, and let the uppers simply retain the foot without making much pressure along the sides or over the instep. Soles and uppers should be made comfortable and convenient with not too much regard for fashion or the exigencies of the trade.

2. Advise him that the arch of the foot is flexible and sustained by the dynamic action of the great muscles of the calf rather than by the static resistance of the ligaments of the foot, and that as the tendons have the difficult task of changing from the vertical to the horizontal direction on their way to the anterior part of the foot, they should never

be hindered by artificial constriction above the ankle. Prescribe, therefore, either very loose laces or low shoes, with the warning that walking will necessarily be painful for a time after the ankles and feet are released from compression, to be followed later by comfort and increased ability. Note: It is difficult to conceive of the weight of the body as sustained alone by the balance of forces in so small an arch composed of bone and ligament.

3. Advise him that, of all the parts of the body, the feet are the hardest worked, and the most sure to wear out. Therefore prescribe frequent rest for the feet.

THE EFFECT OF PRESSURE-LOWERING DRUGS AND MEASURES ON SYSTOLIC AND DIASTOLIC PRESSURE IN MAN.—Lawrence in the *Archives of Internal Medicine* of April 15, 1912, reports his studies on this subject and concludes as follows:

1. The reduction of systolic pressure in cases of hypertension by the use of nitrites, venesection, electricity, or hot air is accompanied by a fall in diastolic pressure amounting, as a rule, to approximately one-half the systolic fall.

2. Such a reduction produces a co-efficient of pressure more nearly approaching the normal than does the co-efficient under the conditions of hypertension.

3. Sodium nitrite reduces diastolic pressure more rapidly than the more complex compounds, thus causing a shorter initial diminution of pulse-pressure than is obtained with mannitol or erythrol. Its effect on the pulse is more marked than that of the other two drugs. The duration of its action is slightly less.

4. None of the nitrite group is efficient for maintaining a pressure at a permanently lowered level, as a tolerance is soon acquired and increasing the dose is apt to cause unpleasant symptoms.

5. Venesection has a more lasting effect in lowering the pressure than have any of the drugs considered in this paper. The diastolic pressure is depressed longer than the systolic, the pulse-pressure thus being increased.

6. The effect of hot-air baths, electric-light baths, and treatment with high-frequency currents is uncertain. A fall in pressure, if produced, is transient.

7. Vasotonin is not certain in its action and is not safe to use in case of showing marked hypertension, an increase of which might bring about untoward results.

NERVOUS DIABETES.—By Dr. Carl Von Noorden (*The British Medical Journal*, May 11, 1912; Ref., *Wein. med. Klin.*, No. 1, 1912). The author discusses a case sent to him under a diagnosis of neurogenic diabetes. The patient was a man forty years of age, with a marked neuropathic family history. Two of his uncles had been diabetics. The patient himself had always been neurasthenical, the prominent symptoms being cardiac in early life and dyspeptic later. Four years ago he began to suffer, under stress of anxiety, from sleeplessness, loss of appetite and weight, and obstinate constipation. The urine was found to contain 1.5 per cent.

of sugar. When under Von Noorden's care the patient's tolerance for carbohydrates was at first considerable; 180 grams (6.3 oz.) of bread daily only resulted on the eighth and ninth days in a slight degree of glycosuria, and this began to diminish on the first day on which the amount of bread was lessened, and soon disappeared. The patient did well, and put on 1 lb. in weight in a fortnight on a diet containing 60 grams of bread (2.1 oz.) Two facts came out as the case went on—first, that a sleepless night may in neuropathic diabetic patients give rise to glycosuria, which, within wide limits, is independent of food; and, secondly, that strong psychical irritation may cause a considerable output of sugar. In this case, as in many others observed by the author, sugar would appear in the urine during the day which followed a sleepless night, even though it might be absent from the urine passed in the early morning, while excitement and anxiety led to such a change in the condition that the patient, who had been tolerating 150 grams (5 oz.) of bread daily began to pass sugar even after a complete withdrawal of carbohydrates. The nervous factor was undoubtedly stronger in this case than the alimentary one, but, in spite of this, Von Noorden did not regard it as a purely neurogenic case and one without risk of alimentary glycosuria in the future, both because there was undoubtedly a certain degree of alimentary tolerance and also because the fact that any excitement was repeatedly followed by the excretion of sugar, showed weakness of the physiological control over the sugar formation of the organism. Present-day knowledge points under such conditions to the presence of some insufficiency, however slight, on the part of the pancreas, and the author has seen true diabetes develop in a very large number of cases from a neurogenic diabetes. This proved to be a case in point. The patient returned to work on a modified diet, and when the urine, a year later, was examined by the family doctor and found to be free from sugar, the doctor recommended a return to a mixed diet. A little later, however, further symptoms developed, and finally, two or three years after the beginning of the first attack, the patient presented himself with all the signs and symptoms of true alimentary diabetes, in which the neurogenic element could no longer be demonstrated with certainty, while limitation of the carbohydrates now produced acetonuria. V. Noorden dwells upon the importance of always regarding neurogenic glycosuria as liable to be followed by true glycosuria, and in any case of the kind here described urges that the true limits of tolerance for carbohydrates should be ascertained and any over-stepping of the limit forbidden.—*The Post-Graduate*.

**PULMONARY TUBERCULOSIS, SPECIFIC TREATMENT AGAINST.**—Mixed infection being usually present in progressive pulmonary tuberculosis and its complications, the author considers the use of appropriate vaccines essential, either before or conjointly with the administration of tuberculin. In 100 cases treated, autogenous vaccines usually seemed to act no better than the polyvalent vaccines made in the laboratory. Under staphylococcic, streptococcic, or pneumonic vaccine with tuberculin, the catarrhal symptoms due to mixed infection very often abated, and it was also found that colon vaccine acts exceedingly well in many cases complicated with severe bronchitis, even though this organism cannot be isolated from the



sputum. Severe cough and profuse expectoration disappeared and moist rales cleared up after injections of colon vaccine and tuberculin alternately. The same treatment, after surgical procedure, gave excellent results in cases of ischiorectal abscess; likewise in cystitis and a case of tuberculous appendicitis with abdominal fistula formation. In cases with pulmonary hemorrhage and rising temperature assuming a septic pneumonic type, polyvalent pneumococcic vaccine often did good. In tuberculous adenitis with sinuses, both tuberculin and staphylococcic or streptococcic vaccine are necessary. In a girl with lupus and keratitis, tuberculin with staphylococcic vaccine produced a wholly unexpected reversal of the prognosis.

The tuberculin used was generally tuberculinum purum, Gabrilowitch's modification, the dose being increased gradually from 1-50 mg. to 10 or 100 mg., or even more. The vaccines were usually begun with 2 to 5 million of dead cocci and increased once or twice weekly up to a maximum of 25 to 50 million. The injections were made with a platinum needle, sterilized in an alcohol flame. A drop of lysol was put on the skin in the subscapular region, the injection given through it, and the lysol wiped away with cotton; no infection ever occurred.

Of the 100 cases treated, 72 were improved, 15 remained unimproved, and 13 died. Concluding, the author states that in the latter stages of tuberculosis or in toxemic cases the purified tuberculin, if given in appropriate dosage and with due precautions, is a useful adjunct to sanatorium treatment. The improvement in the general condition, due to the checking of the intercurrent infection, enables the tuberculin to act favorably upon processes which, had the concomitant bacteria been disregarded, would certainly be more refractory.—James A. Lyon (*Boston Medical and Surgical Journal*, August 1, 1912.)

**PHOSPHATURIA: ITS SIGNIFICANCE AND TREATMENT.**—There has been much discussion over the probable origin of an excessive phosphatic excretion. Normally, the phosphates in the urine are derived almost wholly from the phosphoric content of the ingested food. Whether or not the increased phosphoric acid excretion in pathological conditions is derived from the phosphoric acid contained in the nuclein and lecithin of the nervous system has not yet been determined.

According to Schlagentweit (*Munch. Med. Woch.*, July 4, 1911), phosphaturia is essentially a neurotic secretory disturbance of the kidneys. The irritation causing the nervous disturbance may originate outside of the urinary tract and may act by reflex influences; or it may be due solely to a functional anomaly of the kidney cells. As part proof of the theory that phosphaturia is a local neurotic affection, Schlagentweit cites the frequent association of phosphaturia with neurasthenia, hypochondriasis, intestinal atony and mental strain. He also calls attention to the fact that irritation of the pelvis of a normal or diseased kidney by means of a ureteral catheter causes an increase of phosphates in the urine from the excited kidney, while the phosphatic excretion from the opposite kidney remains stationary.

# Monthly Retrospect

## OF HOMOEOPATHIC MATERIA MEDICA AND THERAPEUTICS

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CONDUCTED BY A. LEIGHT MONROE,

Miami, Florida.

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**MATERIA MEDICA NOTES.**—(George Royal, M. D., Des Moines, Iowa).  
*Actea Racemosa*. Tremors of the entire body; jerking after going to bed, obliging change of position, beginning on side on which he was lying; nervous restlessness with indisposition to fix the attention on any subject; mental restlessness patient constantly changing subject; nausea and vomiting with general tremors and a weak trembling sensation; sharp catching pains about the heart with palpitation and faintness; sleep restless and disturbed by dreams; drawing tensive pains at points of spinous processes of three upper vertebræ which are sensitive to touch; twitching and trembling of muscles of the lower extremities so that he can scarcely walk; jerking constricting, burning pains in extremities.

The aggravations are at the time of menses and from motion. When we take into consideration the fact that this remedy acts upon the belly of muscles especially those of the uterus and the further fact that the larger proportion of the choreic patients are girls and women and the disease which most frequently complicates chorea you will see why *Actea Rac.* is so frequently indicated. Used in the 3d, 6th and 30th.

*Stramonium*. Trembling of whole body; constant restless movements; features continually changing; tongue thrust out rapidly over lips and cheeks; head thrown backward and forward; spasmodic twisting of spine and body; convulsive movements at the sight of a bright light or water; worse from being touched or scolded; stammering speech; speech so impaired that she cannot be understood; spasm of the throat on attempting to swallow, especially water; profuse saliva with difficult deglutition; respiration difficult; breathing oppressive with tightness of the chest; trembling and twitching of the hands and feet; twitching of the tendons, followed by a sensation of numbness. The aggravation from water is characteristic. The grimaces which the twitching of the facial muscles produce are fearful. Used in the 6th and 30th.

*Ignatia*. Emotional chorea, for the chorea of sensitive children who have been frightened or blamed, also for the result of grief or depressing emotions of older patients with the following: *Sadness, weeping*, loss of appetite; diarrhoea; then twitching of the muscles about the corners of the mouth; twitching of the arms and then the legs; hiccough; regurgitation of food; difficult deglutition with constant swallowing; nervous spasms of the glottis; frequent sighing. The jerking of the limbs seems worse as the patient is just ready to fall asleep. Used in the 30th and 100th.

*Hyoeyamus.* Chorea after exhausting disease. Constant clutching motion of the hands on every attempt to move them; twitching of muscles of any parts of the body when thinking about them; trembling of the hands and feet even spasmodically flexed when walking or going upstairs or extending legs; twitching of the muscles of face distorting it; trimus, great weakness; involuntary micturition, used in the 6th and 30th.

*Agaracus.* True cerebral chorea. Frequent *twitchings* of muscles, *especially those of the eye*; trembling; aversion to mental work; twitching of the eye balls so that the type seemed to move; "*swimming*" of the type; spasms of the muscles of the ear; twitching of the muscles of face; *constriction* of the chest; soreness, aching, boring and twitching of the muscles of the spine; convulsive shocks through upper back and head; *attacks one upper arm* and the opposite leg.

*Arsenicum.* This is most frequently used by the old school. Great *restlessness, constantly changes position*; walks to get relief from restlessness; great prostration, inability of stomach and intestines; stools frequent, dark, liquid and exhausting; marked *anemia* as shown by all tests; sleep restless and unrefreshing, worse after midnight; *violent convulsive spasms* of the extremities; *urine scanty* and high colored; trembling of all the limbs; weakness so marked can hardly walk; *sensation of torpor of limbs* as if they were dead. Arsenicum has been used with success in all potencies from 5 drops of Fowler's solution to the 1000th. I prefer the 30th in the majority of cases.

*Nux Vomica.* *Unsteady gait; feet drag*; choreic movements renewed by the least touch of cold air on the parts and by motion but relieved by firm hold or pressure or holding the part firmly.

THE THEORY OF DYNAMIZATION—IS IT SCIENTIFICALLY TENABLE?—John Prentice Rand, M. D. Dr. Rand started out with the proposition that every physician selects the remedy and prescribes the dose which he thinks will do the best for his patient. He then took up the theory of dynamization which Hahnemann evolved, in his declining years, and contrasted his methods of treatment with the barbarous practice of his contemporaries. He next presented a brief outline of the molecular theory of Dalton, and the more recent theory of Thomson, which is known as the electron theory, and showed the utter impossibility of attenuating a drug beyond its elementary particles or constituents. When a drug has been attenuated to the point that only a single molecule or electron is left in it, we have reached the limit of attenuation. He introduced figures to show the comparative bulk of a few of our common attenuations or dilutions: A single minimum raised to the 6x will make a volume of a little more than 16 gallons; the same minimum raised to the 12x would be a million times that amount or 16,000,000 gallons and when carried to the 30x it would make a volume that would occupy 14,781,000,000,000 cubic miles, or a sphere whose contents would be 56.85 times the size of this earth. Is it necessary to dilute drugs to that extent to prevent overdosings? He then referred to the famous Milwaukee test conducted by Dr. Lewis Sherman thirty-two years ago, by which it was demonstrated that the advocates of high potencies in this institute, could not in a full year pick out a vial of the 30c. from nine similar vials containing the inert menstruum, by the



clinical test or any other, and quoted at length from the late Timothy Field Allen, who, after laboring at the problem, for six long years sadly and reluctantly gave it up. Taking up the subject from the standpoint of the high potentist he showed that if their theory of dynamization be true, if the medical properties of a drug are imparted to an inert menstruum by frictional contact, then every atom of matter in the world has been medicated by every other atom that exists. We could no longer prescribe an innocuous placebo, or even the single remedy, since all have been succussed and triturated together in the great mortar of the universe since matter has had an existence. The healing powers of nature are sufficient to account for the beneficent results of many a worthless prescription, and unless we can be sure that the attenuation we use contains some trace of medicine we have no right to claim the subsequent cure as a result of medical treatment. In closing he urged upon all the necessity of using attenuations that can be reasonably shown to contain some trace of medicine if they would preserve the fair name of homœopathy from ridicule and insure the respect of our confiding patients.—*North American Jour. of Hom.*

**SPIGELIA.**—Animals poisoned by spigelia show vomiting, weakness and inco-ordination of movements, restlessness, rapid dyspnoic respiration, and, finally, stupor, coma, and death from failure of the respiratory centre.

Spigelia is pre-eminently a neuralgic medicine. The pains are intense and violent, and may occur in any nerve in the body. The pains are jerking, stitching, tearing, burning; they characteristically radiate and extend to other parts. They are aggravated by noise, jar, movement, stooping, change of weather, especially stormy weather. They are largely outpressing, and extend from within outwards and below upwards.

The spigelia pains are especially apt to occur about the head and face, and spigelia has an important place in the treatment of trigeminal neuralgia and headache. There are stitches in the head which may begin in the occiput, and settle in or over the left eye; stitches like electric sparks in the head; a compressive or expansive headache, with sensation like a tight band around the head. The headache is worse for every jar or step, or straining at stool for the slightest movement or noise, from opening the mouth, from stooping; better at rest and lying with the head high. Another peculiarity is that the headaches increase with the rising of the sun and decrease with its going down.

With regard to its use in trigeminal neuralgia, Hughes says: "When headaches take the form of supra-orbital neuralgia, especially on the left side; when the pain recurs at regular intervals, tends to spread to the face or neck and to involve the eyes, is aggravated by the least concussion or motion, but especially by stooping, and is associated with pale face, restlessness and palpitation, in such circumstances spigelia, in almost any dilution, will prove strikingly curative.

In the mental and emotional sphere, spigelia causes restlessness and despondency with timidity. A peculiar symptom is "fear of pointed things, as pins, &c." This resembles and contrasts with the silica symptom, in which there is a fixed idea; the patient thinks only of pins, fears them yet searches for them, and counts them carefully. With spigelia there is a

confused state of the head, dizziness, and vertigo when looking downwards.

The particular pains of spigelia are very marked about the eyes. There is neuralgia of the eyes with great soreness, an illusion as if hairs or feathers were on the lashes. Pains in the eyes during movement, as if the eyeballs were too large. Digging, boring and shootings in the eyes penetrating into the head; inflammation of eyes and cornea; smarting tears; difficulty in raising eyelids, with painful sensation of stiffness; convergent squint; pupils dilated; luminous rays and sparks before the eyes. Spigelia has accordingly been found of great service in various affections of the eyes, especially in that painful affection, rheumatic ophthalmia, and in ciliary neuralgia, whether occurring alone or in association with inflammatory affections of the eye.

The characteristic sharp stabbing pains of spigelia also occur in the heart. There are shooting pains through the heart and down the left arm, with violent palpitation. There is a feeling as if the heart is compressed or squeezed with a hand, as if the heart is being crushed. The palpitation is worse by curving the chest forward and by sitting down. It is chiefly useful in rheumatic heart disease and in hearts chronically damaged by rheumatism, and is a medicine often indicated in rheumatic pericarditis. "It is not only a very valuable remedy in acute attacks of the heart, but in chronic valvular affections following the acute attack, where we have the loud blowing sounds and attacks of violent palpitation," says Nash, "I have seen the violent attacks of palpitation quickly relieved, and the valvular troubles gradually and perfectly cured under the action of this remedy.

There are one or two curious circulatory sensations caused by spigelia. The pulse feels as if a thread is pulled through the arteries, and in the left scapula there is a sensation as though blood were dripping through a valve. The violent pulsations of the heart shake the body.

With spigelia there is often stoppage and dryness of the anterior nose, with copious discharge of whitish and yellowish mucus, from the posterior nares, and it is a useful medicine in post-nasal catarrh.

The spigelia symptoms are worse by touch, jarring, hard step, motion, rising; from draughts, cold, damp, rainy, stormy weather; cold air and cold washing, and in the morning on awakening; better for rest, lying with head high, whilst eating, for warmth. The pain increases and declines with the sun.

Hughes says: "The higher dilutions in neuralgia, the lower in cardiac affections, have been those generally given."—*British Homoeopathic Jour.*

PROVINGS OF BICHLORIDE OF MERCURY FROM FILLINGS OF TEETH.—Mercurial poisoning in all degrees of intensity is so common from fillings in teeth that it deserves more special attention than is generally conceded in chronic diseases. As a germicide it stands at the head of the list. Tillman's Surgery, Vol. I, page 388, quotes Koch: "Bichloride of mercury will destroy anthrax bacilli when as dilute as 1-300000 parts of water." Lambert's Listerine Pamphlet reports bichloride of mercury as preventing development of fungi when as dilute as 1-100000 parts of water. Nitrate of silver next in order, 1-50,000 parts of water; H<sub>2</sub>O<sub>2</sub>, 1,8000 parts

of water. Hydrargyri chloridum corrosivus, or corrosive sublimate, or bichloride of mercury, symbol  $\text{HgCl}_2$ , is a very poisonous corrosive salt of mercury, and as noted above is chemically composed of mercury and chlorine. Chlorine is a non-metallic element, a yellowish green gas with a suffocating odor; symbol,  $\text{Cl}$ . It is a powerful disinfectant and has the property of discharging colors from cotton, linen and other fabrics, and is one of the essential constituents of the human body. Common salt is a sodium chloride and satisfies chlorine hunger in man and animals; symbol,  $\text{NaCl}$ . Teeth filled with mercury forces continual contact of chlorine and mercury, thus forming a bichloride of mercury without cessation, continuously saturating the system with this poison. *Merc. cor.* is a specific irritant to the living tissues, in which for range and intensity of action it is rivaled only by *Arsenicum*. It has a special affinity for the stomach and large intestines, the respiratory mucous membranes and the lungs, the kidneys, uro-genital organs and the peritoneum. It may affect certain or elective parts, mouth, throat, stomach, large intestines, appendix, etc. It attacks the mucous membranes of the eyes, nose, bronchi and lungs. I am now treating a case of iritis with adhesions, retinitis with great photophobia and general ocular inflammation, which I attribute to mercurial filling of the teeth. This is a chronic case and subject to general cellular inflammation in either eye at any time.

CASE 2.—Dec. 29, 1909, Mr. J. H., aged 37, husky, robust, naturally intelligent, came 700 miles from mining camp to consult me for sore mouth. Had previously consulted twenty-three doctors without relief. Invariably these men were determined to give him mercurial treatment for syphilis, which he refused to take because he said he knew his own career and insisted that he had no syphilis. His teeth were well filled with "silver" for two years. June, 1909, his teeth began to loosen. He had a very severe pyorrhœa. Later his throat assumed a very dark red color and swelled to almost choking. His mouth and tongue were ulcerated. Gums receded from the teeth and nasal passages were ulcerated. His entire system was mercurialized. His toe nails blackened and fell off. Three molars were crowned with gold and this gold was deeply discolored by mercurial amalgamation. These metals have a mutual chemical affinity. The aurum is electro-negative; the mercury is electro-positive. The former is a pentad halogen, the latter is a dyad and may be separated by the electro-chemical current. Some persons are more susceptible to this poison than others and suffer serious inroads on health from which they never recover. It is insidiously active and continuously progressive.

Persons poisoned by this salt of mercury cannot get well by any mode of treatment until the cause is removed. The mouth is a veritable laboratory for the special manufacture of bichloride of mercury. Many cases of chronic diseases, obscure in their nature and far distant from the mouth, are due wholly or in part to this poison.—(N. Bray, M. D., *Homoeopathic Record*).

LACHESIS IN THE TREATMENT OF THE PLAGUE.—H. L. Ray writes to the *Homoeopathic Recorder*: A few years ago my third son had an attack of the plague, and was under the treatment of the two most eminent doctors of the old school, but finding no perceptible improvement in the course of about a week, I was forced to take up the case in my hand to try



homœopathic medicines. My position was like, "The fools rush in where angels fear to tread." I was perfectly conscious of my position and responsibility. But my unbounded faith in homœopathy impelled me to take up that position. Although I had by that time successfully treated a few cases of the plague I was still very uncertain of the success in the treatment of the plague on homœopathic principles, and was equally uncertain of my son's case, and was at a loss to find out the simillimum. As there were six buboes in this case I considered the case to be one of malignant boils or a case of pyæmia, and accordingly gave *Lachesis* 6. To my utter surprise the buboes matured in course of two or three days and were operated by an able surgeon, and my son perfectly recovered in course of two months. This was the first application of *Lachesis* in the treatment of the plague, and I must admit it was a kind of random shot.

CASE No. II.—In January, 1905, I was treating the wife of Babu R. P. It was a plague case, and was ultimately cured. While I was attending on her her son complained to me of pain and swelling on the right elbow, and on examining the place I found a bubo as large as the stone of a plum there. The eyes of the boy were a little bit reddish and he had a wild look. I applied a few drops of *Lachesis* 6 externally, and gave a few doses internally to the boy. The boy was all right next day. The bubo disappeared as if by magic.

CASE No. III.—I was treating the wife of Babu M. N. L., who was then residing at Unao, having his headquarters at Cawnpore, where the plague was then prevailing. The mother of his servant was attacked with the plague in her native village, and was being carried in a bullock cart to the Ganges near Cawnpore, as the last rite of an orthodox Hindu, to be burnt near the Ganges, and to have her ashes thrown into the holy water of the river. She was still alive, and was put in a mango garden with the head low and the legs up, as the bullocks were removed from the cart. When it was known that she was still alive I was requested by Babu M. N. L. and his brothers to try the case. I pointed out to them the posture of the patient, and laughed at their request. But they would not listen to me, and I was obliged to examine the patient, who was to all appearance dead.

I had her placed in a horizontal position, and on examining the pulse I found it was beating strongly. She had a bubo on left side of the parotid gland. She could neither speak nor protrude her tongue, and was not in her senses properly. I gave her *Lachesis* 6, externally and internally, every hour. After taking three doses of medicine she came to her senses, and could ask for water to drink, and her condition seemed better. She was then removed to the empty stable of the Babu, and after three or four days she completely recovered. She is still alive. This case seemed to be a miracle in homœopathy.

Now these cases clearly point to *Lachesis* as a valuable remedy in the treatment of the plague.

# THE HAHNEMANNIAN MONTHLY.

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NOVEMBER, 1912

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## Transactions of the Homoeopathic Medical Society of the State of Pennsylvania

### PRESIDENTIAL ADDRESS.

DELIVERED BY GILBERT J. PALEN, M. D., BEFORE THE HOMOEOPATHIC MEDICAL SOCIETY OF THE STATE OF PENNSYLVANIA, SEPTEMBER 17, 1912.

PERMIT me first to thank the Society for the honor it has conferred upon me and also to thank many of its good members for the courtesy they have extended to me during the few months I have occupied this office.

As I look back over these months and review what I have learned and the effect it has had upon me, I cannot but wish that it were possible for every member of this Society to at some time be its President, for, I can assure you, it would prove to every member an education; true, he would find much to discourage him, but in the main he would find himself becoming enthusiastic; he would glory in the accomplishments of his school; he would store up, as assets, the warm friendships which he had formed with good men throughout the State. Naturally, he would find many conditions needing correction and he would study ways and means of accomplishing these things; above all, he would lose the "ego" in his desire to do good for the general profession. I can assure you that he would find he had less dollars in the bank at the end of his travels through the State, but he would forget these in his increased enthusi-

asm, his increased knowledge of medical affairs and he would say, "Well it's hard work, but I am mighty glad I've had it, for I am now, more than ever, pleased to be a physician, a Homœopath and a member of the Homœopathic Medical Society of the State of Pennsylvania."

As we review the past year, we find it to have been one of great advance in medicine; it has been a year of great changes; a year which marks the beginning of greater changes to come. Some of these changes were heralded last year by our former president, Dr. William A. Stewart, in his most able presidential address.

The requirements for medical education have been raised, and the standard of medical colleges has been very generally increased. In our State, the greatly dreaded single Board of Medical Education has had its first inning and much has developed, many things are in their infancy which may bring future developments of an interesting nature.

Until this year the medical institutions were allowed to go their own ways, the result being that, in many instances, their teachings were insufficient, their graduates ill trained and poorly fitted to pass the rigid examinations of the various State boards. This year we find a tendency to get at the root of the evil; to cure the disease by removing the cause; in other words, the various institutions have been forced to undergo rigid examinations; their equipment, their methods of teaching have been carefully probed.

The work of the Board of Medical Education and Licensure has been a hard one, but one which has brought to light much of interest. It has been a work this year largely of accumulation of data but a work which should mark the beginning of great ultimate improvements if it is carried on as honestly and conscientiously as we believe it has been done this first year. The work of this Bureau will spell for some of our medical institutions either success or failure; it means for these either improvements in methods of teaching or closed doors; it spells for the future the "survival of the fittest"; it means for the graduate of medicine, absolute assurance that if he can pass his college examinations, he need have no fear but that he will receive his license to practice. I shall not dilate upon the work of this Board for this you will hear, later on in our meeting, from Doctor Maddux, suffice it to say, that we as Homœopaths, have every reason to be proud of the excel-



lent comparative showing of our institution and its graduates. I cannot refrain, however, in passing from this subject to mention the peculiar fatality by which we lost from this Board two of our very excellent members, first my very dear and greatly admired friend, Dr. Gustave A. Müller, and our good, old staunch and loyal member, Dr. Seip.

For those of you who wish a knowledge of the law, which brought into existence this new Board of Medical Education I would refer you to the excellent summary of the bill given by Doctor Tuller last year in his report as president of the Legislative Committee; this you will find in the *HAHNEMANNIAN MONTHLY* of May, 1912, page 378.

As members of our Society we owe it to the great State of Pennsylvania to make this State the center, the first in all matters medical. This State must and will ultimately set the standard for medical education. As Homœopaths, we must, in addition, aim to make this State the greatest center of our School and we should as a society and as individuals work with this end in view.

The basis, the very foundation of our professional standing lies in our institutions. The greater these are, the higher standard they set, just so much the greater will be *our* professional prestige, just so much the greater will be the demand for our services. We owe allegiance, we owe our staunchest support to these institutions and especially do we, as members of this Society, owe allegiance and support to our own State institution, the Hahnemann Medical College of Philadelphia.

If we will improve our standing we must look well to our foundations. Permanency of our institutions is necessary for permanency of our school. This permanency can be assured only by endowment. As a Society and as individuals we should not rest until we have seen the accomplishment of this.

We should consider ways and means to increase our strength, to widen our field of usefulness; we should endeavor to secure representation in every section of this State. To accomplish this we should give our support to our graduates, we should interest ourselves in their welfare, we should offer them every assistance to secure their success. While we are thus engaged in aiding the young men we would be materially helping ourselves, for the greater the success of new recruits just so much the greater are we increased in strength as a

school. Every year we find many of our graduates groping blindly about for a location. The career of many of these is stunted and their usefulness to us lost, because of an unwise location and yet there have been constantly excellent locations in our State which would have afforded great opportunities for these men.

Should we not make an organized movement to get together thorough data relative to good locations? Could we not have an active bureau or committee the business of which will be to get such data into printed form; a bureau or committee from which the student can get information and advice upon this subject? Can we not in this way ultimately greatly widen our influence through the State?

We appealed this year to the County Societies for such data. The answers received were most encouraging and the data furnished showed exceptional opportunities widely through the State. Although this material came late to hand, we have every reason to be encouraged by the results, for the list of locations has been perused by many recent graduates and by other good men who had chosen unwisely at first. We have found this work to be received with gratitude by our graduates.

As a school, we need an individual literature, one covering every subject in medicine and given to us by our own graduates. Do you not think we have men well able to give us such a literature? If this will in any way further our progress or increase our standing is it not a matter for our consideration? Why should not our Society be the one to institute a movement looking toward this end. If we could add to this ways and means to promote more widespread interest in scientific discussion and writing by our members could we not further aid our cause? Has not our school been criticised because of our lack of writings? Dr. H. S. Weaver has created a wonderful revival of interest in our Philadelphia County Society this year through his plan of having short papers upon Homœopathic subjects. We all want Homœopathy, we all need Homœopathy and when we get this then we should have more Homœopathy.

Harmony and union are necessary for great accomplishments. Could we not promote greater harmony? Would we not come into a closer union, if we could, by some means establish a closer relation between the County societies and the

State Society? Could we not have delegates elected by each county society, these to form an advisory committee to meet with the trustees of this Society? Would not such instructed delegates bring much of vital interest to the notice of our Society? Would not the individual members of the county societies, through these delegates, feel themselves a greater part of the State Society than they now do?

Many of our good men through the State are apparently lacking in interest in matters medical. This I have learned is due largely to their lack of information. Could we not increase their interest by having a bureau of publicity, which bureau would keep our members constantly informed through the pages of the *HAHNEMANNIAN MONTHLY*, of all matters of interest?

Every member of our Society is an important, a very important part, of it, and if asked, would do his part. We have been greatly impressed with this fact in meeting men through the State, for we have found them always willing and always pleased to be of service. Many of them and especially many of our good older men feel that they cannot be of service. We have impressed upon these men the value of their support, of their encouragement and of their work. Thus far the work of this Society has been done largely by a few members. Why not find ways and means to employ us all?

If we will exist and grow then our institutions must be endowed, our territory through the State widened, and we must force an individuality. We need for these things harmony, a constantly alive organization and greater activity. Is there nothing further we can do than has been done along these lines?



## BUREAU OF OBSTETRICS

AUGUSTUS KORNDORFER, JR., Chairman

### PROPHYLAXIS OF BREAST INFECTION.

BY

A. E. C. RUSSELL, M. D.

FOR a few minutes we will consider the prevention of a malady most frequently observed during the first weeks of lactation, though it may occur at any time prior to and at the time of weaning.

The causes of breast infection are as follows:

1. Exposure to cold,
2. Excessive secretion of milk,
3. Pressure and friction of the clothing,
4. Excoriated and fissured nipples,
5. Inflammation and consequent closure of some of the milk ducts.

Nearly all of these could be eliminated by early proper care and hygienic precautions.

The preventive treatment, particularly where a predisposition to the affection exists, should be adopted for at least two months before anticipated confinement. In addition to strict cleanliness and exposure to air, bathe the nipples daily in cold water, manipulating to develop. Prevent any irritation from pressure by loose clothing.

If the mother is of a scrofulous diathesis constitutional remedies may be administered according to indications—calc. c., sulph., graph., sepia, rhus tox. and phytolacca.

See that the patient does not take cold immediately after delivery,—keep the breasts warm by an extra covering, also protect the arms of the patient. Restrict the amount of liquid diet taken the first three days.

Do not allow too frequent feedings of the babe; the first should be within six hours. Second in three hours, and continue this interval until the milk appears, when it may be diminished through the daytime to two hours. Insist on regular, 15 or 20-minute feedings—(never allow a child to sleep at the breast or remain with the nipple in its mouth unless nursing

well). Give the heavy glands support by muslin slings. You may have to empty the breasts artificially, but not, if you are careful of the diet and are prompt in putting the infant to the breast, seeing that the two breasts are used alternately.

Wash the infant's mouth thoroughly with gauze wet in cold boiled water before and after nursing to prevent irritation from any possible aphthous condition. Bathe the nipples gently before and after nursing with tepid boiled water, after, to remove the milk (never allow it to dry on the parts) drying thoroughly with a little alcohol or spirits in the water, covering with dry sterile gauze. Over this place a clean towel, thus insuring surgical cleanliness of the nipples.

(Pour alcohol over gauze and let it evaporate—a simple means of sterilization.)

If there is any sensitiveness to air or symptoms of excoriation appear, use a weak solution of boric acid instead of sterile water, drying and covering same as before. If fissures appear, sterile medicated application will benefit, as calendula tincture or calendula and glycerine in equal parts.

A nipple shield may be used if relief is not prompt. Aluminum ones sterilized and kept in a sterile boric acid solution worn between nursings, are very efficacious in keeping the nipples healthy.

If there is obstruction due to stagnation of milk, or no child to nurse, gentle massage with both hands well anointed will relieve a full breast easier than a pump. Follow this with proper support by a sling, and you will have a comfortable patient. Do not massage the breasts indiscriminately, for massage of old or indurated areas which may be carcinomatous, is positively injurious.

At the first sign of inflammation, as: Fever, indurated areas which are tender and usually accompanied by a slight redness of the skin, give remedies as indicated, acon., bell., bry. and graph., phyto., phos., etc. Later, ars., hepar., sil., and use prompt measures for relief, for resolution is possible without pus formation at this stage, so do not allow an abscess to form either in the areola, the gland proper or the retro-mammary space.

The safest procedure in my experience is moist heat applied by means of hot bowls, inserting a soft cloth between the bowl and gland, until the pain and swelling are relieved, remembering to cover with warm flannel when the moist heat is remov-

ed. If the inflammation appears late in lactation, or near the time of weaning, apply an ordinary belladonna plaster evenly over the entire gland, leaving the nipple free and cover with a bandage applied firmly enough to support the entire weight of the breast, holding it upward and inward in its natural position. Keep the sterile dressing on the nipples during this process.

By adhering to this simple technique and observing surgical cleanliness, you can prevent lactation mastitis if there is no deformity or tubercular or syphilitic history.

What else do we prevent in doing this? We save the pain and excruciating suffering attending inflammation in any part of the mammary gland. We know how easily it is communicated through fissured nipples to contiguous structures and with what disastrous results—for these indurated areas that follow inflammation either with or without abscess, may develop cancer in a few months or years.

If we can eliminate one cause of this dreaded disease by keeping the "Port of Entry" for infection perfectly healthy, can we call ourselves other than negligent if we ever allow a case of breast infection to develop during lactation?

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### BLEEDING FOLLOWING DELIVERY.

BY

D. C. KLINE, M. D., READING.

If any degree of ill feeling or grudge is engendered in your anatomy through the reading of this paper, please remember that it is presented in response to the solicitation of our esteemed chairman.

A friend once remarked that there were times when all men were "easy" and could be induced to make unwise or foolish investments and promises. No doubt, such was my mental attitude when Doctor Korndoerfer wrote me that second flattering letter. Now, I see but one way out of it, and that is, by the individual members taking up the few stray thoughts I may present and discussing the subject thoroughly from the standpoint of their personal experience.

By the title, "Bleeding Following Delivery," I mean to in-



clude all abnormal discharges of blood at the immediate time and following the birth of the child. This, in my judgment, is a very important subject, for when a woman is thus depleted she is not only weakened, but much more likely or liable to absorb germs and thus develop varying degrees of infection, or even septicaemia.

True it is, that every woman is more or less a law unto herself in the amount of after flow, or lochia, just as they vary in the quantity and quality of menstrual flow. However, I am inclined to believe that ordinarily we give too little consideration to the uterine discharges following delivery of a child.

If we are aware of former hemorrhages following labor, we should, of course, be on the alert during and after subsequent confinements, but in each particular case inquire carefully as to the amount of blood being lost and if in doubt examine the napkins, inquire as to the number used in a given time, character of it, whether clotted or not. There may be a decidedly severe hemorrhage, a concealed hemorrhage filling up the cavity of the uterus, or we may have a moderate, steady flow; either of which may be equally disastrous, though the latter is not so frightful and gives us more time to study and control it. In either event the uterus will be found soft and flabby and we will have the usual symptoms of hemorrhage from any source or cause, such as weakness, sickly pallor; feeble, frequent pulse, dyspnœa, desire for air, restlessness, thirst, and if hemorrhage continues, syncope, and eventually death.

Bleeding following confinement may be occasioned or induced by various causes, such as deficient uterine contractions, atony of the uterus, Bright's disease, degeneration, retained placenta, coagula or clots, polypi, lacerations, inversions, rupture of uterus, hydramnios (excessive quantity of liquor amnii) twin pregnancy, or where the uterus has been excessively dilated from any cause.

If the uterus is not thoroughly healthy and is unusually distended, we are more liable to have hemorrhage, rapid delivery and too sudden emptying of the uterus, so that it cannot contract promptly enough; frequent recurring pregnancies, undue exertion or excitement of the patient may cause relaxation of the uterine walls, and hemorrhage ensues. A ruptured uterus is no doubt more frequently the cause of hemorrhage than we anticipate.

Usually, this unfortunate condition occurs within a few hours after delivery, however, it may appear several days later, and the later hemorrhage or bleeding is more liable to appear where the mother is unable or unwilling to nurse her babe. No doubt, we all recognize the fact that nursing of the babe tends to aid in contracting the uterus and that where we do not have this help the organ remains large and flabby, a condition more or less of sub-involution, and while there may be no trouble as long as the patient remains quietly in bed, when, however, she begins to move about and exert herself, or when her menstrual period first approaches, the hemorrhage or bleeding may appear.

The treatment of after-delivery hemorrhage or bleeding must, of course, vary in accordance with the origin or cause, and degree or severity. Usually, in the severe cases with which we have to contend, the bleeding will be found to come from the placental site after the expulsion of the foetus and placenta.

The vessels of the uterus are more or less torn by the separation of the placenta, the sinuses remaining open, and we would invariably have excessive bleeding were it not for nature's wise provision in the formation of coagula and the prompt contraction of the uterus. The longitudinal, oblique, and circular fibres of the uterus jointly contracting and pulling, actually serve as many little ligatures around these bleeding vessels and sinuses, thus closing them, and hemorrhage is avoided.

If the prompt contraction of the uterus is so necessary in order to avoid bleeding, we will readily comprehend that there should not be any remnants of placenta or secundines left, which could in anywise interfere with the contraction, therefore, be decidedly careful to remove everything thoroughly.

Inefficient and weak contractions during the first and second stages of labor should cause us to be the more vigilant. One important means of prevention is uterine compression, viz., grasping the uterus through the abdominal walls by the hand of the accoucheur or assistant during delivery of the foetus and placenta, following it down, thus stimulating contractions.

The patient should be kept perfectly quiet in the recumbent position, lowering the head and shoulders and if great danger of hemorrhage, even elevating the hips. If hemorrhage occurs

soon after delivery and the uterus is sufficiently open, grasp the fundus with one hand and make compression, introducing the other into the uterus, empty it of placenta and all clots, keeping the hand there in order that its presence as a foreign body may evoke uterine contractions. Moderate pressure upon the uterus with gentle kneading should be continued, but it should be done with care, as rough squeezing or pressure might do serious harm to the womb or ovaries.

If the uterus is emptied of placenta and clots, and hemorrhage continues, we may use the anteflexion method. Introduce two fingers posterior to cervix within the vagina and press forward, with the other hand upon the abdomen press the fundus well forward, thus producing a complete and even exaggerated anteflexion of the uterus, bending the cervix well up to the fundus as though endeavoring to double the uterus upon itself. This will not only act mechanically to check the bleeding, but will likewise stimulate contractions of the uterus.

Another method is to elevate the patient's hips and limbs six or eight inches and lower the head and shoulders, then press back the intestines, depress the abdominal walls just above the uterus and to left of median line until the pulsations of the aorta are felt; when by gentle pressure one can largely control the supply of blood to the womb, just as is done in amputation of hip and thigh. If, however, in spite of all we have done hemorrhage continues and will not yield, do not give up or be discouraged, but with renewed determination follow out a method I have many times contemplated but never found necessary, which has, however, been used successfully by others within a short time, viz., stitching the cervical opening with catgut ligatures, thereby closing the canal and damming up the flow. This, unquestionably, would prove effectual in some cases. These sutures should be removed within twenty-four to forty-eight hours. Should the uterus relax and become flabby, we would have a concealed hemorrhage, which, too, might prove serious, particularly were we to have a ruptured uterus.

Another method is a recent device known as the Momburg belt, which is well worthy of your consideration and may prove highly satisfactory in certain given cases.

Where Bright's disease exists and convulsions are threatened or appear, I am inclined to believe that an excessive flow, or even moderate hemorrhage at the close of labor is a fortunate occurrence and a safety valve to the patient.



Do not forget to give your indicated remedy as promptly as possible, either by mouth or sub-cutaneously, as this will many times give you prompt results and perhaps nothing else be required. This may be aconite, china, ipecac, bella, sabina, millefolium, or whatever the symptoms call for. A teaspoonful of vinegar will many times serve you well. Ergot, the standby of many physicians, will aid you oftentimes, but I am convinced that the mistake is too often made of prescribing it in too large doses; from five to twenty drops will serve you much better than one or two drachms and the after effect will be more permanent. Usually, it should be given sub-cutaneously about the thighs or abdomen, as it acts too slowly when given by mouth in a severe hemorrhage, or if the bleeding is only moderate, half a drachm in half a glass of water, and a teaspoonful given as often as circumstances warrant.

Cold water splashed over the abdomen, or poured from a height upon the bared abdomen, a wet towel flapped over the uterine region, ice may be passed into the vagina, or even into the uterus. Injections of very hot water, temperature from 110 to 120 degrees thrown into the uterus, several quarts or gallons being used slowly and continuously, or alternately very hot and very cold water. Water of moderate temperature will tend to relax the uterus and increase the hemorrhage. Vinegar, preferably hot, injected into the womb following the hot water, or vinegar diluted with hot water, or the vinegar and hot water can be used by saturating a piece of gauze and carrying it well up into the uterus and swabbing it out thoroughly, or allowing it to remain there for a time.

If there is any danger of collapse do not forget the saline injection within the womb or by venous infusion.

Intra-uterine packing of plain sterile or iodoform gauze with cotton tampons well up to the sides of uterus against the vessels may at times be used with good results. Where the uterus remains open and large, the uterine packing will stimulate contractions and the tampons against the vessels aid in controlling the blood supply, but they should be removed within twelve to twenty-four hours.

I am well aware that many able obstetricians will take exceptions to this method, but I have had good results at times and never any ill effects. It must, of course, be done aseptically.

Stimulants may be called for and should be used if possible

to avoid syncope. Nourishment should be given in concentrated form, such as beef tea, or beef extracts, milk, etc. Both food and drinks should be given cold.

When we have been engaged in advance to attend a woman or where we have attended in previous pregnancies and know our patient's peculiarities and tendencies, we can many times prevent these unpleasant experiences by preparatory treatment, endeavoring to bring the woman up to the time of labor in the very best possible health.

A woman of a hemorrhage diathesis, or who has suffered from much loss of blood following previous confinements, should be treated during pregnancy in accordance with her constitutional diathesis, and symptomatically from the homœopathic standpoint.

Within one week after promising this paper, I was called to attend a little tubercular woman. Three years previous to this time she had been quite broken down from the disease; fresh air, nourishing diet, a little homœopathic medicine whenever called for had built her up remarkably well. A learned jurist has said that all things are governed by law, even to the propagation of the world; if it were not for the law of nature many of us would not be here to-day and this law of nature had unexpectedly brought this babe into existence, the fourth little girl in the family. Now, this little mother informed me that her previous confinements had been frightfully bloody ones and she was very anxious. I quieted her fears as best I could, gave her gelsemium, kept her strictly in the recumbent position during labor, made sure that the placenta was all removed, watched and aided the contractions of the uterus. Following delivery I gave her a few drops of ergot, then arnica and arsenicum, alternately for forty-eight hours, this followed by china 2x, and although I could not consent to her nursing the babe, owing to her tubercular trouble, she made a good recovery without any hemorrhage.

#### DISCUSSION OF DR. KLINE'S PAPER.

DR. LANE: I believe ipecac is a remedy of great value in hemorrhage following child birth. Nausea is almost invariably present when it is indicated. Where the placenta is retained the gloved hand should be introduced with antiseptic precautions and the placenta removed.

DR. DIETZ: In cases of hemorrhage in which the placenta is not retained, I believe it is a mistake to pass the hand into the uterus. Where we have sharp pain extending from the pubis to the sacrum, sabina will be found a very useful remedy. Where we have a rupture of a large uterine vessel it is useless to expect a homœopathic remedy to cure the wound.

DR. KLINE: I think it is often difficult for us to determine the cause of post-partum hemorrhage. As I pointed out in my paper, it is more frequently due to laceration of the uterus during pregnancy than to anything else. If the hemorrhage is due to a foreign body it must be removed before the hemorrhage can be controlled. When the woman is not able to nurse her child the uterus is much slower in returning to its normal size.

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#### THOUGHTS ON PRENATAL CONDITIONS AND INFLUENCES WHICH MAY CONTROL THE FORMATION OF SEX.

BY

R. STRAUBE, M. D.

I HAVE come before you this afternoon to speak on a subject which has received the attention and engaged the minds and many of the brightest intellects and most profound thinkers of all times; a subject which has been investigated by scientists, both ancient and modern, and pored over by philosophers in abstract research,—it is the secret of the origin of sex. Many are the theories which have been advanced in explanation of this phenomenon, but so far, all have failed of proof, and the riddle still remains unsolved.

Latterly, however, quite an advance has been made in what seems to me to be the right direction, for the solution of this great question. (Note the Inaugural Address of Professor Shaefer, President of the British Association.) Observe further the successful experiments which have been made at the Johns Hopkins with animal tissue; the fertilization of eggs with a chemical compound and the latest researches in electro-magnetism which have revealed its influence on the growth of the living organism. Judging from the result of these experiments, I hold that electricity in some one of its forms or manifestations, will yet give us the key to the solution of the great secret of the formation of sex. I shall give a few reasons for the faith that is within me.



Thirty-five years ago, being then a medical student, I read every book appertaining to the art of healing, which I could get hold of. Among the many volumes which I devoured mentally there was one written by a disciple of Reichenbach, whose name I have forgotten, but whose work has evidently been enlarged upon by a later writer, Carl Hunter, who wrote a volume on mesmerism entitled "*Menchenkenntnis*," etc. Hunter's relations parallel those of my unknown author in every instance but one, and that one an experiment which Hunter has omitted but which seemed to be of the greatest importance from my point of view, and gave me food for thought. The experiment was described as follows:

The subject, a male, was sent into a vault from which all perceptible light had been excluded, to take up a position and then to remain perfectly quiet. Shortly after, our author entered the vault and remained standing in total darkness near the entrance. He at first saw nothing; but in a minute or so he began to perceive a faint bluish outline or halo encircling the form of the subject, thus locating his position. This halo has been seen again lately by other investigators. I will only mention Dr. Yale of Philadelphia, whose exhibitions of it were very interesting. By him and others this mesmeric halo was called an "aura," but halo or aura, it was there.

Our author repeated the same experiment with a female subject and again saw this halo; but to his astonishment it was yellowish. Further trials established the fact that the male halo was in every case bluish, while that of the female was yellowish. So much for our author. Now, for the conclusions which I drew from his attempts.

First: The blue and yellowish tints suggested to me a positive and a negative,—an anode and a cathode, a male and a female. All three in one but differentiating and reacting on each other constantly and eternally according to immutable natural laws.

Second: The influence and reaction of the blue and yellow,—the positive and negative,—the anode and the cathode, on the formation, transmutation and growth of organic matter and tissue as we see it in electrolysis with its anions and cations, with its electropositive and electronegative elements, raises the question as to whether the same nascent substance or organic compound, if subjected *solely* and *exclusively* to positive or negative influence, reacted or changed in the same way to both influences,

or with different results; in other words, whether the positive and the negative cause the same or different reactions in the same experimented matter, if subjected to their influence separately. This question can be answered only by an experiment which any one here may try if he so lists, and which, if successful will solve the question of sex formation. Now for the trial:

Let us take a large, straight and powerful electromagnet, and place a hen's nest with a setting of fertilized eggs upon each pole, then place a broody hen upon each nest and await results. We have thus one nest absolutely in the positive aura, and the other as absolutely in the negative zone. Now, the positive pole will induce negative (female) magnetism in the eggs placed above it, while the negative pole will induce positive (male) magnetism in the eggs hatched above it. Now if the reactions of the positive and negative magnetisms are different, then we will have nothing but pullets hatched over the positive pole and nothing but cockerels over the negative pole. This is my theory of the determination of sex. The next question which arises if the experiment be a success, is this: How long will it be necessary to expose the eggs to the magnetic aura in order to form and fix the sex, and what amount of magnetic power is necessary to attain results? This question can also be easily settled by further experiments along the same line as before proposed. This question should be elucidated before we try our experiment on the female of the Genus Homo which trial is really the main objective of our endeavors for the solution of this most interesting proposition.

Gentlemen, I offer this theory of the control of sex to any and everyone who may become interested enough to try for the solution; and we should all be interested in it because such solution will ultimately lead to the baring of the secret of life and he who finds that path and forms the key will be honored by posterity forever.

In closing, I would say that electro magnetism is offering us a wide field for scientific research. Let us enter it led by the known laws of nature and endeavor to penetrate it to the utmost limits; just as we would solve a mathematical problem, by advancing from the known to the unknown, using every new fact as another stepping stone towards our goal until consummation is arrived at.

## BUREAU OF PATHOLOGY

J. D. ELLIOTT, Chairman

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### SOME FALLACIES OF URINALYSIS.

BY

J. G. WURTZ, M. D., PHILADELPHIA.

AFTER that epoch in medical history during which delicate physical signs aided in the diagnosis and differential diagnosis of disease, came the era of the clinical laboratory; and urinalysis is the oldest, commonest, most elaborately described and in many instances the most valueless of all laboratory work. Unfortunately too many physicians hold the old theories, cling to absurdities and lay stress upon unimportant and insignificant findings—arriving thereby at false conclusions.

The urine we may regard as an excretion which removes from the body those ultimate products of metabolism which have passed into the blood stream. The character of this excretion in disease, depends chiefly upon certain general factors; as the quality and quantity of diet, condition of digestive and assimilative functions, presence or absence of fever, involvement of various organs in the disease process, certain neurosial tendencies and many other elements. Only in rare cases do specific factors become operative, that cause the excretion in the urine of bodies that can be considered as pathognomonic for any one disease.

While it is of some importance to know the total amount of urine voided by a patient during twenty-four hours, the twenty-four-hour specimen is by no means the best specimen for examination; it is, however, the only good specimen for the estimation of the urine's weight. But the specific gravity is so variable, even normally, that it is of little value diagnostically, save perhaps in diabetes.

The general microscopic character of urine may be judged from its macroscopical appearance. The sediment depending upon the reaction, concentration and salts present. Even normal urine on standing becomes cloudy as you know from mucus, leucocytes and epithelium—along with bacteria. And decomposition leads to an alteration of the chemical and a disin-



tegration of the organized constituents. These changes which occur in all twenty-four-hour specimens are often enough to lead to false deductions. Hence again the fresh specimen is best.

Since the appearance of urine depends so much upon habits, diet, reaction and other such varying factors, the transparency of the specimen is of little or no value. Thick, ropy sedimented urine may suggest a cystitis; but the cause may be elsewhere. Such a sediment is usually due to pus—which in small quantities, does not signify anything—and in large large amounts may point to an extensive cystitis or result from an inflammation of more or less chronic nature anywhere along the genito-urinary passages. Or it may be from an abscess which has broken into the genito-urinary tract. Here other symptoms and signs are of more importance and the cystoscope and urethroscope better aids toward a positive diagnosis. Cystitis may be present with no urinary findings.

The color of urine varies with its concentration. It is affected too by certain drugs, bile and blood. Nothing of a definite nature can be gleaned from color. Should bile or blood be present they tell us nothing diagnostically. Blood pigment in the urine results from many causes—any condition causing a hemolysis of the red cells. The presence of red corpuscles points to congestion or hemorrhage along the passage, or may occur in small numbers normally. The mere finding is not specifically diagnostic, for from whence the blood came can not be told by urinalysis.

While the presence of bile may, generally speaking, be pathological it is by no means pathognomonic. Since it may occur in vesical cancer, acute nephritis, renal abscess, after renal hemorrhage, in infectious diseases, intoxications, severe jaundice, catarrhal cholangitis, carcinoma of the liver and acute yellow atrophy, one can easily see of what little value it would be in diagnosing any one of the above mentioned conditions.

The doubtful formation of bile pigments detracts too from their clinical value. For should they be formed from disintegrated blood pigment, then bile in the urine may have a still greater variance of significance. Disintegrated hemoglobin any place in the body would be responsible for their presence. Bile acids, though always pathologic, have been proven by Croftan to occur in other than liver diseases.

The odor of urine is of no clinical aid in diagnosing a disease. Besides some drugs or food taken—which affect the odor—nothing can be learned from the sense of smell.

Whether urine is acid, alkaline or amphoteric matters little from a diagnostic standpoint. Reaction depends too much upon many factors which may occur normally or in disease. The amount of acidity or alkalinity likewise tells but little. The acidity of urine is increased in nearly all febrile processes, leukemia, scurvy and diabetes. The alkalinity is increased (a part from physiological factors) by the liberation of ammonia or solution of fixed alkalies. Free ammonia may be due to fermentation either in the bladder or upon standing after being voided. Fixed alkali may be due to the withdrawal of acids from the body by vomiting, admixture of alkaline secretions from the urinary passages or rapid absorption of exudates or transudates.

Urates in urine can be told grossly. Their presence is noted in fever, after eating animal food, etc. They occur in variable amounts in both normal and diseased urine; so no conclusions can be drawn from their finding.

The quantity and quality of all inorganic constituents of urine depend largely upon the nature of the person's diet and digestion. Sulphates and phosphates depend on food and assimilation, not usually taken into account in ordinary urinalysis. And the daily fluctuations of chlorides make the result of their estimation nil. Chlorides, phosphates and sulphates yield so little of value that time spent in their determination is time wasted.

A qualitative test for acetone, and other bodies of the acetone group, is one of importance, especially in diabetes. Large amounts are excreted in no other condition. It is present in copious amounts whenever intra-cellular oxidation is interfered with. If very severe, all members of the group may be present.

Here let me mention briefly the non-importance of other substances found more or less commonly in urine.

Mucus, is diagnostic of nothing.

Indol and its allied compounds have a clinical significance which too, amounts to nothing. Indol is present normally and is increased in so many conditions that to depend upon it is foolish. Hippuric acid has a pathognomonic significance which is practically unknown, a clinical significance very small.

Cystin may occur normally without disease signs. If present a stone may be suspected or a disturbance of metabolism.

Leucin and tyrosin, products of proteid decomposition indicating metabolic disturbances, are considered always abnormal. They occur in many diseases, as: acute yellow atrophy, all organic diseases of the liver, phosphorus poisoning, often in typhoid and intestinal tuberculosis. Pathognomonic however of neither.

Cholesterin occurs in one case in about four thousand. When present it points to fatty kidney, nephrolithiasis, hydatid disease of the kidneys and perhaps cystitis. Conditions so allied as to make its value nil.

Fat may be present in urine from many causes, so has no particular significance.

Xanthin is rare and its cause unknown. All the purin bases are only interesting from the standpoint of physiological chemistry; having no clinical value.

Bacteria, yeasts, and moulds point to no specific disease. They are present in all urine especially upon standing for even a short time. *Bacterium urea* and *micrococcus urea* mean clinically nothing. While tubercle bacilli are diagnostic of genito-urinary tuberculosis, they are found in only a small percentage of cases which give the clinical evidence of tuberculosis. The failure then to demonstrate tubercle bacilli, does by no means exclude genito-urinary tuberculosis. Seldom, if ever, do we depend upon the presence of gonococci in the urine to diagnose gonorrhoea. On the other hand, the finding of animal parasites in urine is diagnostic. These, however, are quite rare.

Many urinologists have the practice of naming epithelium after the location from whence it came. Epithelium is usually found in normal urine and in a great variety of conditions both normal and abnormal. Their size and shape—all which can be told of them—is no index as to whether they come from the bladder, kidneys, ureter or where not. The statement that renal cells are present, when small mononuclear cells are seen, is fallacious. They may come from the tubules or they may not. So the report of renal cells is unjustifiable.

Calcium oxalate crystals have no clinical importance. They occur in about twenty-five per cent. of all urine. They do not give any idea of the amount of lime or oxalic acid present. Since the phosphate excretion may be increased without any



precipitation taking place, the phosphate crystals have no clinical significance. They mean nothing in an old specimen and not any more in a fresh one. All crystals are valueless diagnostically. A quantitative test for phosphates may be of some little value, but not worth the time consumed. Phosphates occurring as they do in so many conditions, are even of no aid in diagnosing nervous affections.

On the other hand, the carbohydrates as a group are important. They point to metabolic disorders, and an increase of the total carbohydrates may always be considered as pathologic. Glycosuria, properly speaking, means the excretion of glycose in the urine. Clinically it is used to designate any sugar. It may occur in any functional impairment of the liver cells, nervous disorders, hysteria, chronic plumbism, delirium tremens, etc. Whenever found, however, it heralds danger of diabetes. A transitory glycosuria sometimes occurs in epidemic cholera, malaria, typhoid, scarlatina, pertussis, measles, influenza, nervous disorders, pancreatic disease, after carbuncles and furunculosis. The last two conditions often being associated with diabetes. From this it may be seen that the presence of sugar does not always mean diabetes; but to test for it is important as glycosuria may often be the only sign of an existing diabetes.

Albuminuria—though it may be transitory from any agency that can cause either circulatory disturbances in the kidneys or a transitory flooding of the blood stream with abnormal and poisonous products of metabolism—is important, since a small amount of albumin is sometimes the first sign of nephritis. If found, the cardiovascular changes may then be looked for. The absence of albumin in isolated specimens of urine does not exclude nephritis. In very early irritation of the kidneys and in very late stages of nephritis, when albumin is absent, the diagnosis must be made by the ocular and cardiovascular symptoms and from certain other urinary phenomena.

Serum albumin and serum globulin alone or in combination is always pathologic. Even if transitory it means frequent examination of the urine. Nucleo-albumin points to cellular degeneration and with albumose and peptone is of no account. It is impossible to enumerate the diseases in which they occur. Though serum albumin is a very important urinary finding, Cabot has shown that it is hard to tell the relationship between nephritis and albuminuria. Either can occur without the

other. So to estimate real anatomic conditions of the kidney by the measurement of albumin and search for casts is fallacious.

In the *Journal of the American Medical Association*, March, 1905, Cabot says, in his conclusions upon his work on nephritis, that "There are causes of acute glomerular nephritis which can not be recognized by the methods of examination known to us. In sub-acute and chronic glomerular nephritis the diagnostic resources are likewise at fault, but in the great majority of cases the conditions of the urine taken in connection with other features of the clinical picture aid in the diagnosis. In chronic interstitial cases, only about one-third were correctly diagnosed before death. Senile and arterio-sclerotic changes are not infrequently mistaken nephritis, especially when too implicit reliance is based on the urinary findings. In passive congestion and acute degeneration of the kidney, the urine occasionally simulates that of acute nephritis." And even "in kidneys, which showed no lesions at autopsy," Cabot goes on to state, "the urine was occasionally highly albuminous and full of casts."

As with albumin, casts too are important. Occasionally they may occur normally. Shattuck found them in over sixty-six per cent. of urines of persons over fifty years of age. The hyaline variety are the least significant; but even though they occur in functional disturbances of the kidney, they may be considered pathological and a careful lookout must be established for renal disease. They point at least to a beginning true nephritis. The variety of the cast gives some information as to the extent of the renal lesion. But the type of lesion cannot be diagnosed by the type of cast.

Waxy casts do not always mean amyloid nephritis; clinically they may mean any nephritis of long standing. Pseudo casts and cylindroids point to nothing definite. By the number of casts we may form some idea of the intensity of the nephritis.

Lastly comes the two greatest fallacies of urinalysis: the estimation of uric acid and urea.

To estimate uric acid is a waste of time, for our knowledge of the compound is so hazy, and it is so variable that no clinical meaning can be attached to it. Uric acid is destroyed in the tissues; kidney, liver and muscles, hence urinary uric acid is no index of the circulating uric acid. Besides, uric acid is often times excreted by the bowels. The proof that urea is formed

from uric acid finally demonstrates that uric acid is by no means a terminal product; but is instead an intermediary product between nuclein and urea. In the diagnosis of gout, uric acid is of no aid. Gouty persons excrete it much the same as others; sometimes more and sometimes less in all stages of the disease.

The so-called "uric acid diathesis," along with much that has been written about the urea—uric acid ratio is nonsense.

As for urea, it is foolish to estimate that, without an accurate knowledge of the patient's metabolism. What is measured in estimating urea is not the functional power of the kidneys; but merely their power to take from the blood a certain portion of urea there present. Von Noorden has proven that in chronic nephritis of any type, the kidneys may excrete some substances perfectly well, others less well and still others very poorly. So because urea is poorly excreted does not mean kidney deficient in power to excrete other substances. In nephritis there are, too, periods of good urea excretion alternating at varying intervals with periods when urea is deficient in the urine. Normal kidneys have also fluctuations of urea output, for nitrogen retention is not rare in health or in disease.

Urea depends on the amount of nitrogenous food absorbed by the individual and on the catabolism of the whole body. As the bulk of urinary nitrogen is excreted as urea it has become fashionable to pay particular attention to the determination of urinary urea. Unfortunately many physicians regard it as an index of nitrogen economy of the body and above all an index of the functional power of the kidneys.

Experiments have proven that any calculations of the nitrogen output extending over only twenty-four hours is of very little value in determining the level of the nitrogen equilibrium. Estimation of a single specimen or even a twenty-four-hour one is valueless unless the nitrogen content of the diet is considered. In fact, the nitrogen intake and output of several days is necessary.

Considering the diet regulated, only one step has been taken to make the result of any importance. It is not merely the amount ingested, but the amount absorbed that need be known. And this depends on so many factors, as sleep, exercise, digestion, water taken, presence or absence of fever, vomiting, diarrhoea, presence or absence of cachexia, wasting diseases and heart trouble.



With the patient at rest the urea is more or less diminished. Water taken freely increases urea; water taken from the body by vomiting, diarrhœa, etc., diminishes it. Digestive disturbances and kidney circulation affect the urea output.

Urea estimation performed in the proper way and in experiments lasting over several days may be of some little value—readings should, however, be interpreted with care and conservatism, particularly in drawing conclusions regarding renal inadequacy. It is clear that all this is too complicated for accurate work.

Because it cannot be made a part of a general metabolism experiment, the estimation of the solids in urine is a waste of time.

Since we can depend so little upon things which may occur normally or are inconstant in disease, I conclude that no urinary finding, no matter how abnormal it seems, should be considered absolutely pathognomonic without taking into consideration the clinical manifestations of the disease.

The character of the kidney lesion can not be told by a mere urinalysis.

The test for albumin, sugar, members of the acetone group, the search for casts and occasionally the estimation of the specific gravity are the only important clinical laboratory tests.

I do not mean to be iconoclastic, but it were well that "false idols, ancient and venerated, be overthrown."

#### DISCUSSION OF DR. WURTZ'S PAPER.

DR. NORMAN BETTS: I think a little of iconoclasm is of value for it is a waste of time to make some of these tests. The harm is less than the harm that results from wrong deductions drawn from them. Until a few years ago the estimation of the amount of urea excreted was considered important, but we now know that it is practically valueless. The essayist referred to the fluctuations in the amount of albumin as the result of changes in diet. These fluctuations have nothing to do with the severity of the disease, but, as has been pointed out, any change in the diet, be it a very strict or liberal diet or vice versa, will result in an increase of albumin.

DR. WILLIAM R. WILLIAMS: I think we should not let this paper go without taking issue with some of the statements. The specific gravity is possibly worthless from a theoretical standpoint, but in some cases it may be of great value.

DR. CALEB MIDDLETON: Fifty years ago, when I went to college, we knew very little of urine analysis. Then we thought we learned a great deal about it, but after hearing the paper that has just been read, it seems doubtful whether we know anything or not. With reference to albuminuria in young persons, I recall several cases, especially in young girls, in which albuminuria followed infectious diseases and yet the patients lived a great many years.

DR. R. W. McCLELLAND: I am very much interested in this paper from the standpoint of the general practitioner. It has impressed upon me the fact that the laboratory findings are of only relative value and must be considered in connection with the clinical symptoms of the case.

DR. WURTZ: In regard to albuminuria, most experts now agree that there is no such thing as physiological albuminuria. It is always pathological from the beginning and may develop into nephritis. I do not want to be understood as saying that urine analysis is of no value, but there are many false deductions made from the findings, and it is necessary to exercise care in this respect.

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THE PATHOGENESIS OF CHLOROSIS.—Archangeli believes that the theory of chlorosis being an anæmia due to insufficient formation of blood from weakness of the hæmatopoetic organs primarily, or secondarily to ovarian insufficiency, is not completely in accord with clinical facts and experimental data. Anæmia is a symptom of chlorosis but not the whole disease; it includes many symptoms such as women experience before and during the menstrual period, that is symptoms of premenstrual intoxication. In some cases and at some periods there is exaggerated hæmolysis. Chlorosis should be considered as the effect of an intoxication from the internal secretion of the corpus luteum, insufficiently eliminated by the uterus through absence or irregularity of menstruation, or its excessive abundance. There are chlorites with entire hyper- or hypo-overism. Hypoplasia of the uterus has an important effect on the occurrence of this intoxication and because this depends upon an insufficient development of the ovaries, it depends upon hypoplasia of the ovary. The effect of castration on animals varies with the age of the animals; in adults it does not produce anæmia, in the young there is slight anæmia. Iron improves not the anæmia, but the other symptoms of the chlorosis; probably it counteracts the intoxication. This theory will assist in explaining the occurrence of chlorosis in the spring, and in girls who come from the country to the city. This is due to the absolute change in food and hygiene, and the abnormal stimulation of the ovarian function.—*Abs. Amer. Jr. Obs.* Vol. 65-881.

**CYCLIC OR RECURRING VOMITING.**

BY

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(Read before the Bureau of Pediatrics, American Institute of Homœopathy at Pittsburgh, Pa., June 21st, 1912.)

CYCLIC vomiting is a disease of childhood most frequently occurring between the ages of from three to six years. Cases reported in infants are doubtful because of the common occurrence of vomiting at that age and the important role played by improper feeding in gastric disturbances in infancy. Periodic vomiting occurring at a later age is also more likely to be symptomatic, being found in conjunction with chronic appendicitis, nephritis, gastric ulcer, cholecystitis, etc.

Idiopathic cyclic vomiting is apparently a distinct clinical entity and may be ascribed to the absorption or retention of toxic material which occurs in cycles of varying intervals. The affection first attracted attention in America and in France but of late years the medical literature of England and Germany has produced valuable contributions on the subject. There is still a lack of universal agreement on the etiology and pathology of recurring vomiting.

Predisposing causes are generally conceded, however. Thus, age, the condition being first observed at about three years; social conditions, a predominance of cases occurring in private practice among the well-to-do classes; heredity, a neuropathic or gouty family history—these are factors mentioned by most writers on the subject. Sex appears to play no role.

The exciting cause is usually some factor acting through the nervous system, such as fatigue and excitement. Indiscretion in diet seems to be a negligible factor, although Holt inclines to the belief that the habitual use of a diet excessive in carbohydrates plays an important role. A diet too rich in fat is, to my mind, more important etiologically. Sometimes an attack is ushered in with the symptoms of a cold, and Sedgwick (*American Journal Dis. of Children*, April, 1912) strongly urges the theory that adenoids are the etiologic factor.

The early writers on the subject, notably Marfan in France



(1901) and Pearson in America (*Archives of Pediatrics*, 1902) looked upon the disease as a distinct type of autointoxication because of the presence of acetone in the urine. Edsall accepted this theory at that time and introduced the bicarbonate of soda treatment (*American Journal Medical Society*, 1903). The fallacy of this theory has, however, been laid bare by von Noorden in his investigation of the subject of autointoxication (*Metabolism and Practical Medicine*, 1907). The acidosis is usually a result of the inanition following the persistent vomiting. The correctness of this view is conclusively proven by the prompt disappearance of the acidosis after the administration of carbohydrates. There is probably a disappearance of glycogen from the liver before the acidosis develops and the importance of restoring the same by carbohydrate feeding is self apparent.\*

The association of appendicitis and mucous colitis with recurring vomiting has not been sufficiently constant to prove a necessary etiologic relationship.† Fischl (*Handbuck der Kinderheilk, Pflaundler und Schlossman*) considers the attacks hysterical in nature basing his opinion upon the facts that the affection is seen almost exclusively among the children of the better classes; that the parents are neurotic and that some-

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\*The last word has not yet been said upon this question of the relationship of acetonuria to the clinical manifestation of autointoxication. While as a rule the acetone appears late in the attack and should, therefore, be looked upon as an evidence of inanition only; nevertheless, acetonuria has been observed early in these cases before the vomiting was well established. I have recently had the opportunity of observing such a case. Cautley (*Diseases of Children*) believes that hepatic inadequacy and defective oxidation account for the attack in the so-called arthritic cases and expresses himself as follows:

"The arthritic cases may depend on auto-toxins or intestinal toxins related to or identical with purin bodies, which may account for these attacks, subsequently replaced by migraine. The most important and most dangerous includes those dependent upon hepatic inadequacy. Auto-intoxication is secondary to the inadequacy of liver function. The early stages are hardly those of acid intoxication, but the latter may be partly or entirely due to it. As a rule there is no deficiency of food so the defect must be in the oxidizing powers of the liver and other organs. The fatal cases may occur in fat children and any check of oxidation will induce acid intoxication in a child pre-disposed to it from excessive fat or an undue quantity of fatty food. Poisoning by the products of intestinal putrefaction, indol or skatol, etc., may be an exciting factor in that they reduce the oxidizing power of the tissue cells."

†The association of these conditions is, however, not uncommon and I have found at least a chronic catarrhal enteritis present in a number of my cases. Recently I saw the child of a physician, five years old, with a pronounced mucous colitis developing upon a history of several previous attacks of severe periodic vomiting.

times two children in the same family are affected. Furthermore, the abrupt onset; the intensity of the symptoms yet prompt recovery; the tendency to recur and the fact that hysteria is monosymptomatic in childhood, are strong points in favor of this conception of the disease.

Irving Snow (*Amer. Jour. Med. Sc.*, 1904) found gastric hypersecretion and hyperacidity and, I can confirm these findings but they are more likely symptomatic than etiologic. Various metabolic disturbances have been suggested, *e. g.*, arthritis; deficient oxidation; hepatic insufficiency, etc. Holt (*Diseases of Infancy and Childhood*) found diminished excretion of uric acid during the early days of the attack, pointing to retention of the same prior to the attack. A relationship to migraine has also been urged by some writers and Rachford mentions a case in which migraine replaced the condition in later life.

Sedgwick (*loco cit*) has shown that creatin metabolism, that is, the endogenous nitrogen metabolism is abnormal in recurring vomiting during the attack and also that in some cases creatin may be present in the urine between attacks.

Pathological findings are not characteristic but indicate only secondary changes in the organs. I have observed blood in the gastric contents—coffee ground vomit—and albumin and numerous epithelial casts in the urine in some of the graver cases.

*Symptoms.*—Prodromal symptoms, such as anorexia, malaise and slight fever may be present, but they are frequently overlooked.

Vomiting is the chief symptom, being persistent and apparently not traceable to acute indigestion. It usually continues for from two to five days, being little influenced by treatment. There is no pain and the abdomen is soft and retracted. Nausea is slight or absent. In some cases gastric splashing can be detected pointing to atony of the stomach.

The bowels are constipated and the colon may be felt in a state of spastic contraction. The stools are sometimes light in color. As a rule there is no fever excepting in the early stages.

The child's general condition may become alarming although convalescence is usually rapid and fatalities are rare. Prostration is marked and the child lies in an apathetic state suffering intense thirst but unable to retain even a swallow of water. The tongue becomes dry and pointed, the eyes sunken,

the respirations are slow and shallow and the pulse is feeble. The pupils and reflexes, however, remain normal and Kernig's sign or other evidence of meningeal irritation are never noted. A characteristic fruity odor can usually be detected on the breath, indicating the presence of acetone in the blood. At this stage the urine becomes scanty and contains large amounts of acetone and diacetic acid.

The milder cases subside at the end of two or three days. They are generally encountered in neurotic children, coming on as a rule after overexertion, fright or excitement. Indiscretions in diet and neglect of the bowels may, of course, be preceding factors.

There is another form of recurring vomiting, however, which is far more serious and which is more obscure in etiology. Here also difficulties in differential diagnosis arise, and it is an open question whether some of these cases can properly be classified under recurring vomiting. It has been intimated that the prognosis of recurring vomiting is always favorable excepting for the tendency to recur but with the graver form fatalities have been noted (Crozer Griffith) and I have seen a few cases in which the outlook was dubious although they recovered. The following history of a case I saw last winter with Dr. Shower of York, Pa., illustrates this point:

Richard R., aet 5 years. Family history negative; three other children living and well. At the age of three years had an attack of "gastritis" with pain in the stomach and vomiting lasting several days, followed by a rash diagnosed as measles. Six months later had a second attack of severe vomiting. The third attack occurred after the lapse of a year since which time attacks have recurred more frequently, sometimes with one month interval.

Status praes: Four days ago began to sneeze (which has preceded other attacks) and then complained of pain in stomach followed by vomiting. The vomiting has been persistent. The bowels are constipated. The vomitus has become brownish, giving positive blood reaction with guaiacum test and free HCl. is present. Examination shows a markedly prostrated child with sunken eyes; no fever, weak pulse not markedly accelerated no anasarca; pupils and reflexes normal; mental state normal; abdomen soft, not tender; retracted colon, spas-



tically contracted; gastric splashing. The urine contains acetone, albumin and hyaline casts. Before the attack the urine was normal and two weeks subsequently to the attack the albumin and casts had disappeared.

*Diagnosis:* In mild cases a first attack may not be recognized as a distinctive type of vomiting but a recurrence in the course of several months coming on without the history of a dietetic error should arouse our suspicion of the true nature of the attack. There is still a tendency on the part of some pediatricists to discredit the existence of idiopathic recurring vomiting, but the condition is too well established to be thus ignored.

Simple nervous vomiting frequently occurs in nervous children after excitement or overexertion, but it is of short duration and is afebrile.

Acute gastric indigestion gives a history of an indiscretion in diet and the symptoms promptly improve after the stomach and bowels have been emptied while in recurring vomiting the retching and vomiting persist in spite of all treatment directed to the stomach, in other words it acts precisely as other forms of toxic vomiting, like the vomiting of pregnancy, for example.

Appendicitis and intussusception can be excluded by making a careful abdominal examination supplanted, if necessary, by a rectal examination. In intussusception we encounter a sausage-shaped tumor in the abdomen together with hyperactive peristalsis and often a bloody discharge from the rectum. In appendicitis there is abdominal pain and tenderness over the appendix or a sensitive mass in the appendicular region. A chill is also common in appendicitis in children, while in recurring vomiting it is not observed. If septic peritonitis develops the abdomen becomes distended, peristalsis ceases and the pulse rate is disproportionately high. At this stage the vomiting may become stercoraceous, which it never does in recurring vomiting.

*Tubercular meningitis*, in the early stages, may closely simulate the picture of recurring vomiting. There is the mental apathy; the vomiting without apparent cause and the retracted, non-sensitive abdomen. The pulse and respirations are, however, more irregular in meningitis; involvement of the ocular muscles soon makes its appearance and Kernig's and Babin-

ski's signs are found even in the early stages of most meningeal conditions. Finkelstein (*Lehrbuch der Kinderheilk.*, Feer) cautions against excluding brain affections because of a history of previous attacks of vomiting, as such conditions may present repeated attacks of intracranial pressure with clear intervals. An examination of the eye-grounds is of great value in such cases.

*Acute nephritis* cannot be ruled out at the height of an attack when albumin and casts are found plentifully in the urine, but the absence of oedema and of suppression of urine as well as the absence of blood in the urine and the rapid disappearance of the albumin and casts after the subsidence of the attack and also their absence in the beginning of the attack proves that the albumin is purely toxic and is rather a result of the general intoxication which is causing the vomiting than a leading factor in the clinical condition.

*Treatment* between the attacks will first be considered. As these children are usually of a neurotic temperament and present evidence of defective elimination they should be kept on a diet in which milk, cereals and fresh vegetables play the major role. Meat and fat should be prohibited, and sugar and starch given sparingly, although not too rigidly excluded because of the important role played by the carbohydrates as heat-producing foods and their effect in overcoming acetonuria. Intestinal autointoxication is to be strictly avoided and whenever indican appears in the urine in excess the child should receive a saline laxative and an effort made to have it drink buttermilk instead of sweet milk. Systematic colon irrigation should be practiced in cases having a chronic catarrhal enteritis.

The administration of small doses of bicarbonate of soda—five grains three times daily, after meal—between attacks has proven of some value in lessening the frequency of the attack when the above dietetic precautions are observed.

Remedies, such as calcarea carb., calc., phos., lycopodium, ignatia, ars. iod., etc, are useful in correcting chronic disturbances in the digestive tract or nervous manifestations of long standing. A remedy which I have found useful in migraine in lessening the number of attacks and which is also applicable to cyclic vomiting is sanguinaria which should be administered in doses of several drops of the tincture or 1x dilution after meals.

During the attack the child should be immediately put to bed in a quiet, partially darkened room and all food withheld for

the first twenty-four hours. Cracked ice may be administered and the child may also be permitted to drink three to four ounces of water containing ten grains of bicarbonate of soda several times daily. Even if this is promptly vomited it will greatly relieve the nausea and distress by neutralizing the acid contents of the stomach, and if it should be retained, which is sometimes the case, it will benefit the patient by overcoming the acidosis. The intense thirst is best relieved by means of high rectal enemata of normal salt solution, or if the child is old enough the Murphy treatment may be employed with advantage.

On the second or third day such foods as albumin water, peptonized milk, barley-water and strained rice broth may be attempted, given in small quantities at two hourly intervals.

Among the remedies likely to be indicated I have found iris versicolor most useful. Its symptomatology presents the periodicity, the neurotic elements and the acid hypersecretion which, I believe, is frequently a prominent feature of the attack. When the symptoms are more grave and casts and albumin appear in the urine, arsenicum album is indicated, and when the vomitus is bloody we should think of phosphorus, especially when the characteristic symptom, namely, water is retained until it becomes warm in the stomach and is then promptly vomited, is present. Mercurius dulcis is useful in some cases in which hepatic symptoms predominate, namely, light colored stools, enlargement of the liver, large flabby tongue and foul breath. Numerous other remedies suggest themselves, but these are the ones from which I have obtained the best results.

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#### THE DIFFERENTIAL DIAGNOSIS BY LABORATORY METHODS OF SOME OF THE MORE COMMON DISEASES OF CHILDREN.

BY

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(Read before the Homœopathic Medical Society of the State of New York at Buffalo, October 7, 1912.)

THE differential diagnosis of diseases of children has always been a somewhat difficult matter, for when the physician is first called to see the child he frequently finds the symptoms



which he is able to elicit are common to many conditions no matter what disease has attacked the patient. Thus the child will have flushed face, rapid pulse, more or less fever, restlessness, thirst, etc.

The early differential diagnosis is a matter of importance, especially in those diseases which do not tend to be self limiting. Strict attention should of course be paid to all symptoms which may be obtained by questioning, physical examination, etc., but often times when all such have been taken into consideration, the disease has not been properly classified, and as a result proper treatment cannot be instituted. Thus time is lost at a period when the disease makes its most rapid inroads, and these few days will often mean weeks or months of prolonged suffering for the child.

The resistance of children to disease is poor, and if the condition is not recognized at once, we will find to our sorrow, that the pathologic process has progressed by leaps and bounds, and that our ability to check it has correspondingly diminished, often leaving us with a disease beyond our control, when we have determined what the child is suffering from. When the physician reaches the bedside, he finds a train of symptoms which, when analyzed, will frequently admit of several diagnostic interpretations. It is at this point that laboratory methods will be of the greatest value, and the object of this paper is to show how they may be applied, enabling the physician to make a correct diagnosis promptly, and to institute proper treatment many days before he would otherwise have been able to, had he depended on bedside methods alone.

Let us suppose that the case in hand is a child who has fever, flushed face, restlessness, loss of appetite and coated tongue. The range of diseases under which these symptoms may come is wide. We begin to narrow down the possibilities by making a careful physical examination, and on going over the chest find nothing there. In the abdomen there may be slight tenderness, and if the disease has progressed for a week or more, some enlargement of the spleen. While other symptoms of lesser importance may be present they do not add to our knowledge, and the suspicion of malaria or typhoid is aroused. If the acute condition has been preceded by a prolonged period of illness, tuberculosis must enter into our calculations. At this point the application of laboratory methods becomes of extreme importance.

If either malaria or typhoid fever happen to be present, the blood examination may show normal or diminished hemoglobin, normal or diminished red cells and normal or diminished white cells. The chances are that the polymorphonuclear neutrophils will be diminished, the lymphocytes increased and the eosinophiles normal. If malaria is suspected it will be necessary to look at the large mononuclear cells to see if they contain pigment granules. If we find the granules we are almost certain that we are on the right track, and persist in our hunt for the plasmodium, which, when found, tells us conclusively that the child is suffering from malaria.

Let us go back a step and make some changes in the blood picture. In this new picture as well as the one just brought to your attention, the percentage of hemoglobin is normal or diminished, the total number of red cells normal or diminished, the total number of white cells normal or diminished, the polymorphonuclear neutrophils are diminished and the lymphocytes increased. If the child is over five years of age the eosinophile percentage may approximate that of the adult, that is these cells may be diminished or absent. This condition warrants the suspicion of typhoid, and if the illness has lasted for six days or more in almost every case the Widal will be positive. In addition the blood culture would show the presence of the typhoid bacillus.

To recapitulate, in both malaria and typhoid fever the hemoglobin will be diminished or normal, the red cells diminished or normal, the white cells diminished or normal, the polymorphonuclear neutrophils diminished and the lymphocytes increased. In malaria the eosinophiles will usually be normal, pigment granules present in the large mononuclear cells, plasmodia of malaria present though often very difficult to find and the Widal negative. In typhoid fever the eosinophiles are apt to be diminished, especially if the patient is over five years of age, pigment granules and plasmodia negative and the Widal positive if the condition has lasted for six days or more.

If tuberculosis is present the blood examination will be negative except for normal or diminished hemoglobin, red and white cells, and possibly increased eosinophiles.

The urinary examination in both malaria and typhoid fever is apt to show concentration. In typhoid fever albumin may appear early, the Diazo at the end of the first or the beginning of the second week, and in one third of the cases the typhoid

bacillus will be found. In tuberculosis, on the other hand, concentration is not so common, and it is only at times that a trace of albumin is present.

Let us make a fresh start and change some of the details in our picture. The child now under consideration presents the following symptoms: Flushed face, fever, restlessness, loss of appetite and coated tongue. Physical examination of the abdomen reveals nothing. In the chest, however, there is flatness over one of the lower lobes, and pleurisy with effusion is suspected, but the question presenting is, is the condition serious or has the exudate changed into pus? As in the previous cases a blood examination is made. The hemoglobin and red count tell little other than that they are both usually diminished. In pleurisy with a serous exudate, the total white count is normal and the differential count is normal. Empyema, the total white count may be normal or markedly increased, that is, the total number of cells per cubic millimeter vary between 15,000 and 30,000. The differential count in empyema will, however, vary but little for the polymorphonuclear neutrophiles will be increased at the expense of lymphocytes and the eosinophiles diminished or absent. If with this differential count the total white cells are normal the conclusion to be drawn is, that there is no absorption of pus taking place; in other words, the pus that is in the chest is well walled off. If, on the other hand, the total number of white cells shows a marked increase, then absorption of pus is taking place.

To recapitulate: In pleurisy with serous exudate the hemoglobin and red cells may be diminished; the total number of white cells is normal and the differential count normal. In empyema the differential count will always show an increase in the polymorphonuclear neutrophiles at the expense of the lymphocytes, and the eosinophiles will be either diminished or absent. If there is non-absorption of the pus the total white count will be about normal, while if there is absorption of the pus, the total number of white cells will range between 15,000 and 30,000.

Let us suppose another state of affairs: The child has fever, flushed face, restlessness, loss of appetite, coated tongue and the physical examination is negative. The chest shows us nothing and the abdomen shows us nothing; still fever is, and has been present, and if a definite history is obtainable, the morning and evening temperature has in most instances shown



marked variation. Examination of the blood presents the following picture: Hemoglobin and red cells normal or diminished, total number of white cells varying between 18,000 and 30,000; the differential count gives a marked increase in the polymorphonuclear neutrophiles with the eosinophiles diminished or absent. This blood count certainly points toward pus in some part of the body, but, as there is no evidence of it in the chest or abdomen, we turn to the kidneys and examine a specimen of the urine. The total amount passed in twenty-four hours is diminished. Usually the amount passed is very small and turbid, highly acid, and contains a moderate amount of albumin. Pus is present in large amounts and epithelia from the pelvis are present in varying amounts, usually in large numbers and frequently in large masses. Unless a nephritis accompanies the condition, hyaline casts and epithelia from the tubules of the kidney are found only in scanty numbers. In about seventy-five per cent. of the cases we find the colon bacillus. The result of this examination is conclusive evidence that we are dealing with a pyelitis.

Let us suppose, however, that the urinary examination is negative. The chest and abdomen negative and that our blood examination indicates the presence of pus in some part of the body. We have excluded everything upon which one can ordinarily place his finger. In such a case there is one organ in the body which stands out above all others where this lack of symptoms but proof of pus is present. That organ is the ear, and careful examination of it will frequently show some bulging of the drumhead, which if lanced, is in many instances followed by rapid improvement in the child's condition.

To recapitulate: in pyelitis the blood shows hemoglobin and red cells normal or diminished, total number of white cells varying between 18,000 and 30,000, polynuclear cells increased, almost always markedly so, lymphocytes diminished and eosinophiles diminished or absent. Urinary examination shows concentrated, turbid urine, with high acid reaction and moderate amount of albumin, pus in large amounts and epithelia from the pelvis frequently in large masses, with the colon bacillus present in seventy-five per cent. of the cases. Pus in the middle ear gives the same blood picture and negative urinary findings.

Many other interesting phases of disease might well be con-

sidered in this same manner, but these few examples point conclusively to the fact that the application of laboratory methods to the differential diagnosis of diseases in children is essential.

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## **A STUDY OF THE BLOOD PRESSURE IN 500 CASES OF INSANITY.\***

BY

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(Read before the Homœopathic Medical Society of the State of New York, October 8, 1912.)

THE area of cardiac dulness, stethoscopic inspection of the heart sounds, pulse rate per minute, character of the radial pulse, systolic blood pressure in millimeters of mercury and urinalyses were recorded in each of 500 male inmates of the Gowanda State Hospital for the insane. Sphygmographic radial tracings were taken in 385 cases. Faught's and Janeway's modifications of the Riva Rocci sphygmomanometer with the wide arm cuff were employed. The millimeter of mercury at which the full radial pulse returned after obliteration of the brachial artery comprised the method of technique, care being exercised to have the apparatus, arm and heart on an approximate level. The systolic blood-pressure (intra-arterial pressure during ventricular systole of the heart) was taken in the sitting posture excepting in the helpless bed patients. The diastolic pressure (the ebb of repose to which the intra-arterial pressure falls during diastole of the heart) was disregarded because the therapeutic effect upon the lowering of the blood-pressure and prognostic inquiry are not the objects under consideration. Most of the readings were observed from 2 P. M. to 4 P. M., extending over a period of one year.

In cases presenting heart affections or an elevation of blood-pressure urinalyses were repeatedly made so as to determine the clinical evidence of nephritis with a certain degree of accuracy.

The average normal arterial blood-pressure before middle life is held to be 120 millimeters and 130 millimeters after that period. As a result of the wear and tear, sclerotic changes and

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\*Printed with permission of Dr. D. H. Arthur, Supt. of Gowanda State Hospital. I am indebted to Mr. W. E. King for laboratory assistance.

impairments of the cardio-vascular and renal system, it is no doubt true that an increased blood-pressure is effected so as to maintain an equalization of blood supply. Here a slight elevation of blood-pressure (about 130 m.m. to 150 m.m.) may be of no great importance from a prognostic standpoint, but, the fact remains, that some pathologic process exists that is responsible for this physiologic compensation, and it is this phase of the subject that is held significant in these observations. Janeway, the foremost authority on blood-pressure, asserts that he seldom sees a systolic pressure of 140 m.m. or more in a normal individual. His recent analysis of 500 cases presenting 170 m.m. or more showed a mortality of 150 of the total number in the course of eight years. The importance of recognizing this condition and also a hint as to its prognostic value are taught in this data. In an analysis of 1,247 members of a progressive insurance company, it was found that those who presented a measurement of 150 m.m., or more, contributed a mortality two and a half times greater than the general average death rate of the Company. A pressure of less than 105 m.m. is considered to be below the normal range limit. It is on the intelligence of the above figures, offered by skilled men, that the convictions of this report are based.

#### GENERAL CONSIDERATIONS.

It is the experience of clinicians that arterial blood-pressure rises gradually in advancing years. Table A corroborates this evidence, although it is obvious that the averages of 274 patients given here are comparatively low, in fact, unduly so. Explanation of this low index can be based on the fact that the mode of life and habits of these patients examined are under institutional control while the tabulations of others are founded on readings or subjects independent of institutions, especially applicants for life insurance. The dement who has led an institutional existence since youth, escaping the numerous deleterious influences conducive to heart, arterial and renal diseases, is a subject of proof as to the advantage of hygiene, environment, diet and regulation of habits afforded by our hospitals for the insane. This type, comprising the dementia praecox group in the main, features particularly in this determination. Vaso-motor tone is no doubt lowered in the com-



plete dement who leads a vegetative existence. In this consideration of blood-pressure readings confined to the minimum normal limits it must be mentioned that the chronic bed patients (37) are responsible to a small degree for this low range of readings.

TABLE A.

Relative Increase of Blood-Pressure in Advancing Age.\*  
(274 cases)

No.	Decade,	Average blood-pressure.		
34.	20-30 years .....	110	m.	m. Hg.
78.	30-40 years .....	112	"	" "
75.	40-50 years .....	117	"	" "
58.	50-60 years .....	120	"	" "
20.	60-70 years .....	128	"	" "
9.	70-100 years .....	129	"	" "

In table B, it will be seen that the highest average blood-pressure readings are observed in the class of patients regularly employed at manual labor. Aside from the conceded fact that their mental deterioration is kept in abeyance by occupation, the physical health, especially the heart action, general circulation and character of the pulse, is appreciably better than that of the idle dement and bed patient. The idle patient displays a lower average pressure than the employed. Prolonged rest in bed in cases of varied psychoses results in low tension.

TABLE B.

Influence of the Mode of Life upon Blood-Pressure.†  
(256 cases)

No.	Class of patients.	Average Reading.		
42.	Employed .....	119	m.	m. Hg.
177.	Idle .....	116	"	" "
37.	Bed .....	110	"	" "

#### IMPAIRMENTS OF THE VASCULAR SYSTEM.

Pathological affections of the heart, arterial system and kidneys, encountered so frequently in insanity, are to be recog-

\*Cases presenting arrhythmia, nephritis and cardiac disease, with or without nephritis, are eliminated.

†Cases presenting arrhythmia, nephritis and cardiac disease, with or without nephritis, are eliminated.

nized in part as the result of the debilitating influences, infectious fevers and excesses that form the etiology of many psychoses.

An attempt to diagnosticate early stages of arterio sclerosis is on such a weak foundation and so precarious from an objective standpoint that a selection of only those patients with definite radial atheroma and tortuous temporals are considered. The arterial tree, particularly the arterioles, becomes less pervious and elastic in advancing years so that an increased blood-supply is asserted to be necessary to furnish nutrition. The virtue of a rise of blood-pressure in this condition is appreciated by the argument that there must be some method of nature to maintain physiologic nourishment so as to protect and conserve life. There may or may not be an elevation of blood-pressure in simple arterio sclerosis. (Table C.) This variation is probably dependent upon the location and extent of sclerosis in the arterial tree.

**TABLE C.**

**Simple Arteriosclerosis.**  
(22 cases)

No.	Tension.	Range of Pressure.
12.	Hypertension .....	140-170 m. m. Hg.
10.	Normal .....	100-135 m. m. Hg.

Contradictory to this viewpoint many clinicians hold that hypertension is not uniformly essential to atheromatous changes in the arteries but are inclined to suspicion a diseased kidney as a complication of arterio sclerosis. The following Table (D), giving the total number of cases of nephritis, determined clinically, with or without arterio sclerosis, seems to suggest the plausibility of hypertension as a very frequent symptom of nephritis.

**TABLE D.**

**Blood-Pressure in Nephritis.**  
(166 cases)

No.	Tension.	Range of Pressure.
124.	Hypertension .....	140-220 m. m. Hg.
33.	Normal tension .....	110-138 m. m. Hg.
9.	Hypotension .....	95-105 m. m. Hg.

The most common condition is the affiliation of a chronic interstitial nephritis with a general arterio sclerosis. Their association is so close that it is quite impossible to describe them separately. Whether the renal disease is primary with resultant vascular changes or shares with general sclerosis of the vascular system, cardiac hypertrophy will occur secondarily, because of the effort to overcome arterial resistance. A hyper-tonic contraction of the arteries induced by some irritative stimulation, viz., toxic products of syphilis, over-indulgence in alcoholic beverages, etc., increases blood-pressure and if continued, those circulating irritants produce a hyperplasia of the muscle fibers of the media, the connective tissue of the intima and occasionally affect the adventitia. Pathological changes in the kidneys may therefore be the result of nutritional disturbance through interfered circulatory supply. It is assumed that this obstruction to the renal function causes an elevation of the blood-pressure reading. The latter conclusion is illustrated in 136 cases of hypertension (140 m.m. Hg. or more) where signs of chronic nephritis in 124 were observed. No diagnostic symptoms of nephritis connected with urinalysis were noted in the remaining 12 cases. In these 12 cases of elevated tension not attended by the clinical findings of nephritis one was a hemiplegic and the remaining 11 arterio sclerosis. (Table E.)

**TABLE E.**

**The Frequency of Hypertension.**  
(136 cases)

No.	Associative Condition.	Range of Pressure.
124.	With nephritis .....	140-220 m. m. Hg.
12.	Without nephritis .....	140-170 m. m. Hg.

The symptom syndrome of a chronically contracted kidney consists of urinary findings of nephritis, arterial sclerosis, secondary cardiac hypertrophy of the left ventricle without valvular lesions, accentuated second aortic sound and elevation of the blood-pressure. The thirty-eight cases indexed in Table F are examples of this cardio-vascular renal complex. The seven cases showing a normal tension gave definite auscultory evidence of weakened hearts apparently due to overwork entailed by the long continued high blood-pressure.



TABLE F.

**Cardio-Vascular Renal Complex.**

(38 cases)

No.	Tension.	Range of Pressure.
31.	Hypertension .....	140-220 m. m. Hg.
7.	Normal tension .....	110-135 m. m. Hg.

In cardio-renal disease the heart is primarily diseased. Mitral valve lesions result in a chronic passive congestion of the kidneys. An interstitial nephritis may of course be associated with valvular incompetency and occasion a hypertension. In uncomplicated valvular lesions of the heart where no signs of nephritis were found in the examination of the urine all blood-pressures (25) were confined to the normal range, while valvular lesions complicated by symptoms of nephritis (18) exhibited an elevation of blood-pressure, ranging from 140 m.m. to 210 m.m. (Table G.) Failing energy of the heart muscle is shown by a gradual fall of blood-pressure, this latter condition presenting a decline to normal after a long continued high pressure, thereby misleading interpretation of existing impairments.

TABLE G.

**Valvular Lesions of the Heart.**

(43 cases)

No.	Associative Condition.	Range of Pressure.	Average.
25.	With nephritis .....	140-210 m. m. Hg.	168
18.	Without nephritis .....	100-130 m. m. Hg.	113

**INFLUENCE OF MENTAL DISEASE ON BLOOD-PRESSURE.**

In the consideration of the influence of mental disease upon the tonicity of the vasomotor system it is quite necessary to take frequent observations throughout the course of the psychosis so as to obtain dependable data. Minor fluctuations of the blood-pressure which occur physiologically during the day may contribute misleading results, likewise, disease of the internal organs, especially a nephritis. All cases presenting blood raising or lowering factors must, therefore, be eliminated before attempting to establish weighty conclusions.

In mania with a well pronounced psycho-motor activity the arterial pressure is rather consistently lowered, the same rising to normal upon recovery. Fatigue is no doubt the cause of this fall while recuperation is accompanied by the return to normal.

Only in depressive states where there is a decided agitation do I find an appreciable elevation of blood-pressure returning to normal upon the cessation of the agitation. The impression on the blood current is no doubt caused by the reflex psychic influence that stimulates peripheral vasomotor contraction.

Dementia praecox has no bearing on blood-pressure except in episodes of excitement where the pressure mounts 10 to 20 m.m. Excitability manifested in other types of insanity may also exhibit this elevation.

In the dilapidated general paretic a hypotension is the rule while variable pressure exists in the incipient and moderately advanced stages.

A pressure within the normal range was noted in two cases of cerebral syphilis, the autopsy examination of which showed large gummata of the brain.

In post-apoplectic insanity the blood-pressure is, as a rule, profoundly high. The invariable association of a nephritis and arterio sclerosis embarrasses the investigation of intracranial pressure as a possible elevating factor. The signal sign of a fatal prognosis is a decided fall of blood-pressure immediately after a hemorrhagic attack this drop being also significant of a failing heart.

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## PRESENTATION OF A CASE OF PERFORATED GASTRIC ULCER.

BY

E. M. EBERHARD, M. D., PHILADELPHIA.

(Read before the Tri-County Medical Society, June, 1912.)

My idea in presenting Dr. K. to you this day is, not to give you a long array of complex tests and tiring remarks, but to present a man, who, after having gone the rounds of many physicians, almost succumbed, while a patient in a hospital, for want of knowledge of the simplest tests, and recognition of symptoms that every physician and surgeon ought to know.

In September, 1911, I was called to see Dr. K., and found

him confined to a hospital in a very precarious condition; his temperature 103; pulse 140; respiration 40; abdomen markedly distended with special tenderness two inches above and one inch to the right of the umbilicus. Excessive tenderness in the region of the pylorus. Vomiting was continuous, not even water remaining in the stomach for more than a few minutes. Patient was so irrational that he could give but few intelligent answers. Considering the length of time Dr. K. had been unable to eat, plus the persistent temperature, his emaciation was extreme. Some vomitus examined at the bedside, showed a very high acidity, with an abundance of occult blood.

His nurse told me that he had been given nutriment enemata regularly, but they were expelled almost as soon as injected.

Furthermore, it was impossible to pass the tube any longer on account of a most irritable external sphincter, and the development of a very acute ulcer. Here, then, was a sorry plight. Something had to be done, and that quickly, if we were to save his life.

Considering the very classical symptoms of ulcer present, viz., pain relieved by eating, to return one to four hours afterward; vomiting of food eaten from one to two days previously, acid eructations, especially early in the morning, before breakfast, which, if food were not taken at once, would give rise to violent pain. With this there was a history of recent hemorrhage and a persistent tenderness to the left of the twelfth dorsal vertebra.

Lastly, the disappearance of all these symptoms for a short period to again return, made such a classical picture, that everyone of us must recognize a typical ulcer cycle.

Now, a little more in detail—Dr. K.'s family history is negative. Twenty-one years ago he had typhoid fever. As long ago as thirty years he began suffering with symptoms referable to his stomach. These were evidenced mostly by pain, one to three hours after eating, accompanied by acid eructations, etc. These symptoms would disappear for a long period to return again. As years went on, these symptoms appeared at closer intervals, and seemed with each attack to grow more violent.

About fifteen years ago, vomiting first occurred. In the beginning, he vomited food only that was eaten at the meal before, but gradually he noticed that he would also vomit food eaten two or three days previously. Gradually, the pain, acid



eructations, and epigastric discomfort became so intense that vomiting was his only relief. After vomiting relieved these symptoms, the only diet that he could take was milk. His symptoms continued paroxysmally until September 26th last, when, suddenly, in the early morning, the doctor awoke with intense nausea, vomiting and a severe boring pain in the epigastrium. On trying to arise to assist vomiting, his pain became so agonizing that he collapsed. Coincident with this, he felt something give way in his stomach as if fluid were escaping from it. A physician was summoned, who advised his removal to a hospital. Upon admission to the hospital, the doctor presented the symptoms exactly as I have stated, and, after being confined there two weeks, no diagnosis was made excepting that of indigestion.

During his stay in the hospital, he was permitted to eat what he desired; yet, everything taken was immediately ejected. As patient's condition grew worse, I was called, and had him removed to the Hahnemann Hospital, Philadelphia. There, an examination revealed an obstructed pylorus, hyperchlorhydria, and evidence of persistent bleeding from an open ulcer.

In consultation with Dr. William B. Van Lennep, it was decided that our patient was too weak to operate, and that our only hope lay in the chance of increasing his strength and stopping hemorrhage. We applied icebags to the entire abdomen, and began feeding per rectum, in the usual way, but soon had to stop on account of an irritable ulcer and intolerance.

In desperation, I looked for another source to keep our patient alive, and was rewarded by feeding per rectum nourishment as we do saline by proctoclysis.

This method, gentlemen, I would like to bring to your attention, since it permits feeding during a long period, and gives very little discomfort to the patient. I have used it now in many cases, and have yet to see a single case in which it has failed. At first, I began feeding milk and eggs peptonized, plus common table salt. Later, I found that I could feed many other substances in the same way.

I will bring to your attention only those which I have found to act best, viz., one egg, nine ounces of milk, a teaspoonful of essence of pepsin, and one-half teaspoonful of common table salt. This is allowed to drop slowly, and takes about one and one-half hours for the entire mixture to flow into the bowel.

Another formula is: Two raw eggs and a quart of normal saline allowed to drop as ordinary rectal proctoclysis.

This we did with Dr. Kelly, and, to our delight, found he soon was gaining strength and stopped vomiting. His distention disappeared, pulse became slower and stronger; mental condition markedly improved, and, in four weeks from the time of admission to the Hahnemann Hospital, we were able to operate.

(A very important point to remember in feeding by the drop method is to give a high saline flush every morning to keep the bowel tolerant, just as is done in ordinary nutrient feeding.)

The operation was performed by Dr. William B. VanLennep, who has kindly volunteered to write his findings, which are as follows:

Dr. K., 43 years; room 32 Hahnemann Hospital.—Operation, Oct. 31, 1911. Ether anæsthesia: vertical incision through right rectus. Stomach very firmly adherent to liver, and anterior abdominal wall. On breaking up the latter, a large subphrenic, food and gas abscess was opened, evacuated, and drained with iodoform gauze. A small opening in the stomach, from which the leak had occurred, and which originated in a gastric ulcer, perforated. This was freshened, and closed by a purse string suture of celluloid thread reinforced by Lembert sutures of the same material. It was protected by a cigarette drain coming out of the upper angle of the wound alongside the gauze pack in the abscess. The stomach and colon were then turned out, the transverse mesocolon broken through and a typical, no loop gastro-enterostomy carried out with a double row of sutures, chromic gut inside and Pagensticker thread outside. The line of incision was attached to the opening in the mesocolon to prevent hernia and the abdomen closed by interrupted celluloid sutures through and through. The dressings were sterile gauze and adhesive; the patient was put up in the exaggerated Fowler position, and continuous proctoclysis instituted. The wound healing was prompt, and no peritonitis developed. The stomach perforation, however, broke open, and that, with the subphrenic abscess required drainage of the same for six weeks, the gastric secretion causing the usual very annoying skin irritation.

This finally closed entirely and up to date there is no sign of incisional hernia.

One week ago I had his stomach X-rayed and present to you the plates taken. I want to read to you the result of the fluoroscopic examination. During one-half hour's study, no food left the pylorus. At intervals, which suggest sphincteric action, food could be seen to pass through the gastro-enterostomy. The peristaltic waves pass up to the opening, and then, would be interrupted, and would again begin on the opposite side of the opening, and pass smoothly to the pyloric region on the greater curvature. On the lesser curvature, the wave becomes interrupted at about one and one-half inches from the pylorus.

This, in all probability, is due to adhesions on the site of the old ulcer.

Just a word regarding fluoroscopic examination of stomachs:

In this method, we can frequently diagnose lesions absolutely beyond the control of the clinician. An ulcer, for instance, in one of the curvatures may be recognized by an interruption of the peristaltic waves, etc.

A few of the many recognizable conditions easily seen under the fluoroscope are:

1. Hour glass contraction.
2. Adhesions.
3. Tumors of the stomach wall.
4. Sinuses from stomach to an abscess cavity.
5. Potency of a gastro-enterostomy.

A study of the peristaltic waves has too long been neglected, and should always be resorted to when a stomach diagnosis is in doubt.

In conclusion, let me say, that Dr. Kelly's case teaches us that:

First: Any stomach complaint which lasts longer than a reasonable time, viz., one month, must be considered more than "Indigestion."

Second: The word "Indigestion" is a collective term, and really means nothing. The ulceration of the stomach, pylorus and duodenum, give a well defined symptomatology, which is almost pathognomic, viz., pain relieved by food, acid eructations, vomiting, hemorrhage, etc.

These symptoms, with their cycle of absolute relief and recurrence, point to the well known condition,—periodicity, which is characteristic of ulcer.

Third: That nutrient feeding by the time-honored tube



method is antiquated, and should be replaced by drop feeding, which is less objectionable; that an early recognition of the ulcer cycle in Dr. K's case would have prevented the perforation and lessened by far the danger to which this patient was subjected by operation.

Fourth: That when hemorrhage and collapse occurred in Dr. K's case, in all probability, his perforation occurred, and, if recognized, would have materially lessened his suffering, etc.

Fifth: That gastro-enterostomy in the hands of experienced men, is one of the greatest achievements of modern surgery.

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## EARLY DIAGNOSIS AND TREATMENT OF LARYNGEAL TUBERCULOSIS.

BY

J. HENRY HALLOCK, M. D., SARANAC LAKE, N. Y.

(Read before the Homœopathic Medical Society of the State of New York at Buffalo, October 7, 1912.)

If we are to believe Bosworth we start out with rather a gloomy outlook when we are asked to treat a case of laryngeal tuberculosis, for he says when this disease is a complication of pulmonary tuberculosis the average duration of life is but eighteen months as against three years for a straight pulmonary tuberculosis.

It is to be regretted that an examination of the larynx is so infrequently made when we are making our first examination of the lungs. It is such an important part of the respiratory tract and to one used to laryngoscopic work should aid in the diagnosis, and by a little practice we can learn to recognize the condition long before the pear-shaped arytenoids, turbaned epiglottis, perichondritis, or ulceration of the cords has developed. If we wait for these old and advanced conditions to appear our treatment must mean defeat in a large percentage of our cases.

In a beginning tuberculosis a weak voice has long been recognized as indicating a weak chest. Of course this weak voice may be due to a slight laryngeal catarrh, or some slight condition of paralysis. But in a catarrhal condition the mucous membrane is evenly congested and covered more or less with a catarrhal secretion; whereas in a beginning tuberculosis the

tubercular deposit shows itself by a mottled congestion and these localized patches are easily recognized; the whole upper respiratory tract of a tubercular patient, if he is run down and anæmic, has a distinctive pallor, and especially is this true of the larynx, and you are very safe in calling the case tubercular if you find with this on one side of the larynx an arytenoid cartilage or a cord persistently red and thickened. At this time the patient may complain of a tickling or pricking sensation in the throat, with dryness and a slight hacking cough; but often there is little annoyance in the very beginning; yet they usually have some sensation of tenderness on swallowing.

One of the most constant abnormal pictures revealed by the laryngoscope in an incipient tuberculosis is an elevated plate like thickening of the mucous membrane of the posterior commissure. This is usually reddened but may be edematous. This plate-like elevation generally occupies the middle of the commissure, and usually has a vertical depression running through its center, separating the elevation into two even halves. This I consider one of the sure signs of beginning tuberculosis. Later this elevated tissue may break down into ulcers. About the time this elevation shows at the commissure or a little later, one may find a thickening and reddening of one cord. This is most often found near the posterior insertion and this may soon develop into a small ulcer with a white slough. This ulceration is in spots and it leaves the cord looking as if small pieces had been nibbled from its edge.

The characteristic feature of a tuberculous ulcer is the multiple character and their tendency to run together. Frequently the posterior part of the cord is entirely eaten away, while the anterior portion is but slightly diseased.

The false cords are often infiltrated and sometimes overlap the true cords. This congestion is apt to be patchy. The arytenoids often show localized patches of redness, looking mottled and angry, long before definite lesions are found. The pear-shape swelling does not develop until later, and after this appear conditions and symptoms which used to be considered as necessary for the diagnosis of laryngeal tuberculosis; but now known to indicate an advanced disease.

We all have our own way of dealing with this advanced tuberculosis and it is only a matter of individual choice whether we use the electro-cautery, curet the ulcer, or use the usual lo-

cal applications. We are bound to lose a large percentage of these patients, due to the destruction of tissue, and the rapid development of poisons which completely undermine the patient's vitality; besides, this condition always accompanies a well developed pulmonary tuberculosis. When recognized early and followed up with the proper treatment the result is very gratifying for a large percentage of patients will recover.

Our difficulty as specialists is that the general practitioner is consulted first, and often times the matter is not considered serious enough for consultation until it is advanced far beyond the incipient stage.

In treating laryngeal tuberculosis we must remember that the same general regime of fresh air, feeding, rest, etc., is demanded as in pulmonary type and nowhere is the benefit of rest treatment better proven. In addition to this we must carry out a plan of local treatment. Personally, I do not believe in as strong applications as are used by many, and usually begin by cleansing the parts thoroughly with alkalol one-half strength. After a few minutes' wait, follow this with a 10 per cent. solution of argyrol, which application should be made daily. Good results are frequently obtained by alternating the argyrol with an application of equal parts of tincture of iodine and glycerine to which 10 grains of potassium iodide have been added.

When ulceration of the cords exists it is doubtful if anything gives much better results than the old lactic acid treatment, though I usually alternate this with formalin. Many prefer silver nitrate and not without reason.

As homœopaths we must remember that the indicated homœopathic remedy is our main stay. The patient should not be allowed to talk at all, not even whisper; but must communicate his wants by signs, or paper and pencil, as absolute rest is important.

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THE CAUSE OF APPENDICITIS.—Dickinson (Jersey City) believes that the sequence in the production of appendicitis is as follows: Overeating of high proteids; residuum in the cœcum—decomposition; cæcoappendicitis; cœcum draining and recovery. Appendix not draining, goes on to destruction. Drainage insufficient, subacute appendicitis, with hyperplasia. Drainage good, chronic appendicitis, tendency to fibrosis.—*Amer. Jr. Obs.* Vol. 65-284.



**BUREAU OF MEDICAL EDUCATION AND LICENSURE OF THE STATE OF PENNSYLVANIA.***Group A.*

List of colleges whose graduates are eligible to medical licensure in Pennsylvania by reciprocity and examination:

Leland Stanford, Jr. University, Medical Department,	
	San Francisco, Cal.
University of California, Med. Dept.	San Francisco, Cal.
University of Colorado, School of Medicine,	Denver, Col.
Yale Medical School	New Haven, Conn.
Northwestern University Medical School	Chicago, Ill.
Rush Medical College	Chicago, Ill.
Indiana University, School of Medicine	Indianapolis, Ind.
Drake University School of Medicine	Des Moines, Ia.
State University of Iowa, School of Medicine	Iowa City, Ia.
Tulane University of Louisiana, Med. Dept.,	New Orleans, La.
Johns Hopkins University, Med. Dept.	Baltimore, Md.
Harvard Medical School	Boston, Mass.
Tufts College, Medical School	Boston, Mass.
University of Michigan, Dept. Med. and Surgery	
	Ann Arbor, Mich.
University of Michigan, Homœopathic College	
	Ann Arbor, Mich.
University of Minnesota, College Med. and Surgery	
	Minneapolis, Minn.
Washington University Medical College	St. Louis, Mo.
Dartmouth Medical School	Hanover, N. H.
Columbia University, College of Phys. and Surgeons	
	New York City
Cornell University, Medical College	New York City
Syracuse University, College of Medicine	New York City
University and Bellevue Hospital, Medical College	
	New York City
Starling-Ohio Medical College	Columbus, O.
Ohio-Miami Med. Col. of Univ. of Cincinnati	Cincinnati, O.
University of Texas, Dept. of Med.	Galveston, Texas
St. Louis University, School of Medicine	St. Louis, Mo.
University of Virginia, School of Medicine,	Charlottesville, Va.
Medical College of Virginia	Richmond, Va.
University College of Medicine	Richmond, Va.
University of Vermont, College of Medicine	Burlington, Vt.

Boston University, School of Medicine	Boston, Mass.
University of Nebraska, College of Medicine	Omaha, Neb.

*Group B.*

List of colleges whose graduates are eligible to medical licensure in Pennsylvania by examination only:

University of Alabama, School of Medicine	Mobile, Ala.
George Washington University, Dept. of Med.	

	Washington, D. C.
Howard University, School of Medicine	Washington, D. C.
University of Louisville, Med. Dept.	Louisville, Ky.
University of Buffalo, Med. Dept.	Buffalo, N. Y.
Eclectic Medical College	New York City
College of Physicians and Surgeons	Los Angeles, Cal.
Hahnemann College of the Pacific	San Francisco, Cal.
Oakland College of Medicine and Surgery	Oakland, Cal.
Bennett Medical College	Chicago, Ill.
Hahnemann Medical College and Hospital	Chicago, Ill.
University of Kansas, School of Medicine	Kansas City, Kan.
Baltimore Medical College	Baltimore, Md.
College of Physicians and Surgeons	Baltimore, Md.
University of Maryland, School of Medicine	Baltimore, Md.
Detroit College of Medicine	Detroit, Mich.
University Medical College	Kansas City, Mo.
John A. Creighton Medical College	Omaha, Neb.
State University of Oklahoma, School of Medicine	
	Oklahoma City.
Baylor University College of Medicine	Dallas, Texas
Eclectic Medical College	Cincinnati, O.
Laval University, Medical Faculty	Montreal, Canada
Halifax Medical College, Med. Dept.	Dalhousie Univ.
	Halifax, N. S.
College of Physicians and Surgeons	Chicago, Ill.
Laval University, Medical Faculty	Quebec, Canada
University of Georgia	Augusta, Ga.
Medical School of Maine	Portland, Maine
University of Oregon, Med. Dept.	Portland, Oregon
Manitoba Medical College	Winnepeg, Canada
McGill University Medical Faculty	Montreal, Canada
Queen's University Medical Faculty	Kingston, Canada
University of Toronto, Medical	Toronto, Canada
Western Reserve University, Med. Dept.	Cleveland, O.
Vanderbilt University	Nashville, Tenn.

## EDITORIAL

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### THE DISCRIMINATION AGAINST HOMŒOPATHIC PHYSICIANS BY LIFE INSURANCE COMPANIES AND EDUCATIONAL INSTITUTIONS.

It does not require a very discerning observer to discover here and there relics of the days of medical persecution and of the time when opposition to a homœopathic physician was considered a commendable sign of orthodoxy on the part of practitioners of the traditional school of medicine. It is interesting to note that, while the members of the dominant school have grown more liberal toward practitioners of homœopathy and have, in many instances, been very solicitous in their efforts to induce graduates of homœopathic institutions to become affiliated with their medical societies, their attitude of opposition toward practitioners of homœopathy is still very evident in regard to positions carrying with them pecuniary remuneration. Notable examples of this policy will be found in the opposition to the appointment of homœopathic practitioners as examiners for life insurance companies and as physicians to schools and colleges.

We believe that we are safe in making the assertion that fully twenty-five per cent. of the insurance issued in policies of one thousand dollars or more, in the State of Pennsylvania, is written upon the lives of homœopathic practitioners and their patrons, and yet a careful inquiry into the matter fails to reveal a single homœopathic practitioner who holds any important position in connection with the medical department in any of the large insurance companies.

There are instances in which physicians who had been partially promised an appointment were afterwards rejected because of the fact that they were graduates of a homœopathic institution. The only instances in which we are aware of homœopathic physicians being associated with insurance companies in the capacity of medical examiners are in the case of local companies, in which they own part of the stock, or in the companies writing industrial insurance where the fee for examination averages about fifty cents.



We are informed by a gentleman connected with one of the prominent insurance companies in this State that between three and four hundred thousand dollars a year are expended by the companies in Philadelphia alone for medical examinations. Under any just distribution of this work twenty-five per cent. should find its way into the hands of homœopathic practitioners. As a matter of fact, they secure practically none of it.

We have made it our duty from time to time to inquire of the officers of the various insurance companies as to why this state of affairs exists, and we find that in almost every instance the blame is placed upon the medical director who is invariably an old school man and who appoints members of his own school to these positions. The explanation offered by the medical directors has usually been that homœopathic practitioners were not properly qualified in diagnostic lines. If such an objection ever had any foundation it no longer exists, as the education of homœopathic physicians in Pennsylvania and in many other states, is under the supervision of the same Bureau of Medical Education as the physicians of the dominant school. The truth of the matter is that no rational excuse can be offered for such a policy and it is purely a case of those who are *in* grabbing it all. We have been advised by those who are in a position to know, *that conditions in this respect will not be changed until homœopathic physicians make it evident that they are desirous of obtaining what rightfully belongs to them.* There is no doubt, however, but that an emphatic protest properly made to the insurance companies would result in an early rectification of the matter and in the securing of a proper proportion of the work to be distributed among practitioners of homœopathy.

Aside from the financial loss to the members of the homœopathic school by such an attitude on the part of the insurance companies, there is another feature in this discrimination which is derogatory to members of our school, namely, the fact that many persons believe that because homœopathic practitioners are considered incompetent by insurance companies to make proper examinations of their risks, that they are therefore incompetent to make proper examinations for diagnosing the ailments of their patients. Such an inference would be perfectly justified were homœopathic practitioners barred from

positions with insurance companies because of their lack of skill or knowledge; but such is not the case and inferences based upon such an assumption are unfair to members of the homœopathic school.

In regard to the attitude of colleges and private schools toward homœopathic practitioners, the matter has been recently brought to the attention of the profession by Dr. Edwin Lightner Nesbitt in a short article on the subject in the September issue of the *Journal of the American Institute of Homœopathy*. Dr. Nesbitt is located at Bryn Mawr, the center of a large educational community and has had full opportunity to acquaint himself with the devices that are employed by practitioners of the dominant school to secure special opportunities for the introduction of allopathic methods and allopathic treatment among the students of the various schools and colleges. In a case of illness the school doctor, who is invariably an allopath, is called in attendance and, unless the student is unusually insistent, he is retained.

In many instances special rules have been devised to insure that the patient shall not get out of the hands of the college doctor. An example cited by Dr. Nesbitt is a rule which requires that the student be removed immediately to the infirmary upon the suspicion of illness and to be placed under the care and observation of the college doctor *for three days without expense to the student*, after which time a bill is rendered for the doctor's services. It can readily be seen that such a rule is well calculated to accomplish the purpose for which it is devised.

As Dr. Nesbitt has pointed out, the injury to homœopathic practitioners in such cases, does not end with the loss of the individual case for the time being, but children who have been brought up in homœopathic families are in this manner induced to abandon homœopathic methods and they and their future families are in this way won over to the old school.

It is not our intention at this time to make any suggestions as to how these conditions should be remedied. We are convinced, however, that if a portion of the time and energy expended by our societies in useless denunciations of non-homœopathic methods of medical practice and in collecting facts and fancies which have very little determining influence upon any one, were expended in working out these practical matters which have a direct bearing upon the practice and influence of

homœopathic physicians, we would not only more readily secure the interest and active co-operation of homœopathic practitioners in the work of our societies, but we would do much more to advance the interests of our school in a very substantial way.

G. H. W.

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**SOME REMARKS ON THE ACTION OF THE STATE BOARD OF MEDICAL  
EDUCATION AND LICENSURE OF THE STATE OF PENNSYLVANIA  
IN RELATION TO THE ADMISSION OF GRADUATES  
FROM COLLEGES OUTSIDE OF THE STATE.**

IN the present issue of the *HAHNEMANNIAN MONTHLY* will be found a list of the colleges whose graduates are eligible, either by reciprocity alone or by reciprocity and examination, to obtain licenses to practice medicine in the State of Pennsylvania.

A careful perusal of this list will reveal at once the high standard of requirements that have been set in Pennsylvania. Medical practitioners who desire to advise prospective students of medicine as to the selection of a medical college, would do well to preserve this list for future reference, in view of the fact, of the one hundred and twenty-nine medical colleges in the United States, the graduates of only thirty-two are entitled to reciprocity and thirty-four to admission by examination, while the graduates of the remaining sixty-three medical colleges are not eligible to secure licenses in Pennsylvania either by reciprocity or examination. Furthermore, there are but two homœopathic colleges outside of the State of Pennsylvania whose graduates are entitled to reciprocity in this State and but two more whose graduates are eligible for examination.

It might seem, upon first consideration, that the Bureau of Medical Education and Licensure has drawn a very close line in this matter, but it would be manifestly unfair to the colleges of Pennsylvania who comply with the high standard set by the Bureau, to have graduates enter from other colleges or other states that have not enforced an equal standard.

The Bureau has, after a careful study of the various medical institutions in the United States, divided them into three classes.



The first group (See Group A, page 851) includes those whose graduates are eligible to enter upon the practice of medicine in Pennsylvania by reciprocal transfer from any other state that enters into reciprocal relationship with Pennsylvania.

The second group (See Group B, page 852) includes those colleges whose graduates are eligible to present themselves for examination for licensure before the Bureau but who are not eligible for admission by reciprocity.

The third group (including all medical institutions not specified in the two previous groups) includes those colleges whose graduates will not be admitted to practice in this State either by reciprocity or by examination.

The Bureau did not deem it wise to follow the method of listing "accredited" medical colleges and giving to each college a special "credit" as done in New York. Under such an arrangement it is necessary for a medical student to supplement his education by a degree from a college that is classified as "registered" before he is permitted to appear before the State Board of Examiners.

Under the rulings of the new Bureau, reciprocal transfer in and out of Pennsylvania, is based upon the facts that the applicant is a graduate of a college of satisfactory standing in the state to which he desires to be transferred, that he has earned the right to practice by passing a Medical Board examination and, if he desires to enter Pennsylvania, that the applicant has been at least two years in practice in the state from which he desires to be transferred.

In pursuance of the policy of the new Bureau to place Pennsylvania in the van of medical progress, it was moved and carried at a meeting of the Bureau of Medical Education and Licensure on November 1st, 1912, that "*after January 1st, 1914, the Bureau of Medical Education and Licensure will require for admission to a medical college, in addition to a standard four-year high school course or its equivalent, not less than one year of college credits in chemistry, biology, physics and modern language other than the English language or the equivalent thereof, to be determined by the Bureau of Professional Education, and for examination for license to practice medicine in the State a year of practice as a hospital interne in an approved hospital or a year of post-graduate instruction approved by the Bureau of Medical Education and Licensure, and that the necessary amendments to our medical act be secured at the*

*coming session of the Legislature by a committee to be appointed by the president of the Bureau."*

This important step in regard to entrance requirements for the medical schools in this State was brought about with the full concurrence of the Deans of every medical college in the State. Great credit is due to Dr. John Baldy, President of the Bureau, and to those associated with him, for the conscientious and effective manner in which they are carrying out the work of advancing the standards of medical education and progress in Pennsylvania. It is pleasing to note that the medical institutions in Pennsylvania are amply qualified to comply with the new standards and, with the stimulus and encouragement that has been given them by the Bureau, there is every reason to believe that their graduates will not only surpass the standard set by any other State in the United States, but will conform fully to the standards demanded in European countries.—G. H. W.

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TREATMENT OF MAMMARY FISSURES.—Arquellada, (*Revue de chirurgie*) advocates the application of tincture of iodine to fissures of the breast. Since iodine causes considerable pain when directly used on mammary ulcerations, the affected region is first painted with one per cent. solution of novocaine. The child should not be given the breast for from four to six hours after the application, and nursing from the affected organ should be preceded by washing with tepid water of the whole area to which iodine has been applied. The breast as well as the infant's mouth, should also be washed with a solution of hydrogen peroxide before and after each nursing throughout the period of treatment.

The iodine is used on alternate days, and a cure is generally obtained after two or three applications. In a series of twenty-eight cases treated by this method, cure was obtained in every instance in less than ten days, without complications.—*Charlotte Med. Jour.*

CANE SUGAR IN MYOCARDIAL DEGENERATION.—Simon (*Birmingham, England, Medical Review*) reports the case of a woman aged sixty-six years, suffering from pronounced circulatory weakness due to myocardial degeneration, in which "extraordinary" benefit was derived from the ingestion of large amounts of cane sugar. The patient had been treated with strophanthus, caffeine, saline purges, and later, digitalis, and potassium iodide, without much success, the dyspnea, cyanosis, and edema increasing until it appeared that she could not have many days to live. One ounce of lump sugar was then given morning and evening (later increased to four ounces per diem), with the result that the pulse became regular, its rate dropped from 110 125 to 88 96 and later to 72 84 a minute; the edema disappeared, the patient became alert and active, and finally left the hospital entirely free of discomfort. He concludes that, given a suitable type of case, sugar is at least a valuable adjunct in the treatment of obstinate cases of heart failure due to deficient heart muscle without valvular lesion.

## GLEANINGS

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REMOVAL OF THE TONSILS. In the *Maryland Medical Journal* for June, Dr. John N. Mackenzie, professor of laryngology and rhinology in the Johns Hopkins University, inveighs against the indiscriminate removal of the tonsils, which he attributes not only to mistaken views of the American profession but to insistent demands of the laity. He points out that the functions of the tonsils are at present unknown. Whether they are portals of entrance or exit for infection, whether they protect the organism from disease or invite its entrance, whether the pathogenic bacteria sometimes found in them are coming out or going in, whether they are manufacturers or storehouses of leucocytes, and whether their destruction means the removal of a battle-line against the passage of infection from the throat to the neck cannot be stated. Until these questions are settled the final word on removal of the tonsils cannot be said. Whatever its functions, the tonsil is not, as is generally believed, a lymphatic gland. Its physiological integrity is important in childhood. It appears in the fourth month of embryonic life, attains maturity at the end of the first year of infancy, and about puberty tends to diminish in size. It does not develop as a lymphatic gland from a plexus of pre-existing lymph-vessels in the mesothelium, but as an ingrowth of endothelium from the second branchial pouch, and therefore resembles the thymus and thyroid, which originate respectively from the third and fourth branchial pouches. All these bodies are produced by inbudding of the endothelial lining of the primitive pharynx. In a recent careful study in comparative anatomy Gordon Wilson, of Chicago, has shown that the tonsil secretes or excretes into the pharynx. The role of the tonsils as portals of infection Professor Mackenzie considers greatly exaggerated. He admits that they are so in certain cases, but to a less extent than the more abundant and receptive lymphatic structures of the nose and naso-pharynx. The tonsils are frequently held responsible for the results of morbid conditions situated elsewhere. If obstruction to respiration due to adenoids be removed, the tonsils will often take care of themselves. Even if they remain large and are causing no trouble they may be safely left, and as growth of the child proceeds they will become less conspicuous. The mere size of the tonsil Professor Mackenzie considers no indication for removal. A large tonsil does not necessarily mean a diseased one, nor does a small one mean a healthy one. That the tonsil has some important healthy function is shown by its frequent growth after enucleation. Another point is that the tonsils play an important part in the mechanism of speech and song. They influence the action of the surrounding muscles and modify the resonance of the mouth. On the other hand, they may be so enlarged as to cripple both these functions, and then should certainly be removed. The changes in anatomical relations produced by tonsillectomy cannot be fore-



told, no matter how skilfully the operation is performed. The adhesions and contractions which sometimes follow, even in the best of hands, often ruin the singing voice. Professor Mackenzie shows that he would long hesitate before advising the operation in a great singer, or one depending on the voice for a livelihood. He considers that tonsillectomy is a dangerous operation which should be done only in a hospital or other place where there is every facility to meet the gravest emergency. It should be done only by a surgeon skilled in its performance, thoroughly equipped for every accident, and fully alive to the fatalities which have sometimes followed. He does not decry the many excellent measures which modern ingenuity has devised for operation on the tonsil when there are definite reasons for their application.—*Lancet*.

THE TRAINING OF THE NERVOUS CHILD.—In his admirable address on the Care of the Nervous Child, Dr. Barker, according to *Life and Health*, states that, above all, it is important to overcome the tendency to give way to emotions. Children should early be given to understand that they must control themselves before they can get what they want. The child must learn that it is more apt to get what it seeks if it controls itself than if it gives way to an emotional outbreak. Beginning later in life, it will be found almost impossible to control this emotional instability.

Vacillation is another characteristic which must receive especial attention in childhood. Parents should see that the child finds in them no example of this failing. While a few children of the "hair-trigger" type need to be taught deliberation in making decisions, most children should be encouraged to make a decision and stick to it.

Another matter parents must guard is the criticism of neighbors. Such criticism favors a malevolent spirit, which has a most pernicious effect on the nervous system.

But the child should not be protected from everything which might stir his emotions. He needs such experiences in order to learn self-control. While a hot temper is bad for the child, it is less damaging than a habit of holding a grudge, which grows by degrees into the persecutory ideas of the paranoid state.

But at best sudden outbursts of emotion or passion, if frequently repeated, are very deleterious to the nervous system. The attempt to avoid or overcome these attacks either by petting or by punishing is not apt to end well. As a rule, it is best to ignore the attacks, and, as far as possible, forestall them. To older children one can explain the lack of dignity and senselessness of giving way to anger. Such lessons given during the season of calm will often have the desired effect.

A mistake often made by parents, and oftener by nurses, that of frightening children with stories of the boggy man, the policeman, etc., is apt to set up nervous disturbances which last through life. One must learn how to deal with the fear of being alone, the fear of the dark, and the fear of thunder and lightning. Certain of these fears are easily overcome, especially by an example of courage on the part of older persons.

Sometimes fear is a symptom of disease, and the child should be examined by a physician. Night terrors, for instance, may indicate the presence of adenoids.

But we must not think that a lack of feeling is desirable, or that it protects against disease. We should not forget that the emotions have very much to do with the child's future nervous make-up. The elevating emotions are constructive, helping to build up a strong nervous system; the depressing emotions, if long continued are damaging and have the opposite effect.

The child should be given the highest development possible, but always at a suitable age. It is a mistake to give children experiences at an age when they can not be appreciated. "The child's childishness is its greatest asset."

One of the greatest pleasures and the best protection is the joy of work, but avoid overwork. The best tonic is enjoyable work. The country is a more favorable place in which to rear nervous children than is the city.

Nervous children should not be sent to school too early, and should not be pushed ahead too fast. Competition is dangerous to the nervous child. Sleeplessness is a danger signal. In children it is too often due to indigestion, mental overstrain, or premature sexual excitation. If it persists a physician should be consulted.—*Amer. Medicine.*

INFLUENCE OF MUSCULAR EXERCISE AND THE OPEN AIR ON THE BODILY FUNCTIONS.—Hill says that all the efforts of the heating and ventilating engineer should be directed towards cooling the air in crowded places and cooling the bodies of the people by setting the air in motion by means of fans. In a crowded room the air confined between the bodies and clothes of the people is almost warmed up to body temperature and saturated with moisture, so that cooling of the body by radiation, convection, and evaporation becomes reduced to a minimum. The strain on the heat-regulating mechanism tells on the heart. The pulse is accelerated, the blood is sent in increased volume to the skin, and circulates there in far greater volume, while less goes through the viscera and brain. As the surface temperature rises, the cutaneous vessels dilate, the veins become filled, the arteries may become small in volume, and the blood pressure low, the heart is fatigued by the extra work thrown upon it. The influence of the heat stagnation is shown by the great acceleration of the pulse when work is done and the slower rate at which the pulse returns to its former rate on resting. The increased percentage of carbonic acid and diminution of oxygen which has been found to exist in badly ventilated churches, schools, theatres, and barracks, is such that it can have no effect upon the incidence of respiratory disease and higher death-rate, which statistical evidence has shown to exist among persons living in crowded and unventilated rooms. The conditions of temperature, moisture, and windless atmosphere in such places primarily diminishes the heat loss, and secondarily the heat production—that is, the activity of the occupants, together with the total volume of air breathed, the oxygen taken in, and the food eaten. The whole mechanism of the body is thus run at a lower plane, and the nervous system and tone of the body are unstimulated by the monotonous, warm, and motionless air. If hard work has to be done it is done under conditions of strain. The number of pathogenic organisms is increased in such places, and these two conditions run together—diminished immunity and increased mass influence of infecting bacteria. The bodily mech-

anisms become trained to maintain the body heat by habitual exposure to open-air life. The risk lies in overheating our dwellings and overclothing our bodies.—*British Med. Journal.*

**HYPERACIDITY.**—G. R. Lockwood, New York. Lockwood suggests the following practical rules for diagnosis:

1. Do not make a diagnosis of hyperacidity until all organic lesions are excluded and even then be prepared, with a free and unbiased mind, to change the diagnosis to one that is more definite and distinctive, should other symptoms or physical signs arise.

2. Do not make the diagnosis of hyperacidity without examination of the fasting stomach by a tube. The presence of acid fluid, or of food remains or of any considerable amount of gastric mucus should exclude the diagnosis.

3. Do not make the diagnosis of hyperacidity simply because the patient is nervous and neurasthenic.

4. Do not make the diagnosis of hyperacidity should the previous clinical history suggest attacks that may point to appendicular or gall-bladder disease, or should the physical examination suggest that these lesions are probable.

5. Do not make the diagnosis of hyperacidity accompanied by epigastric pain. Especially should this diagnosis be avoided if the pains occur at a stated and regular time after eating.

6. Do not make the diagnosis of hyperacidity if hemorrhage is present either visible or occult, in vomited matters or in the stools. Examination for occult blood in the stools should never be neglected.

7. Do not make the diagnosis of hyperacidity in cases with repeated vomiting, especially if vomiting be of the abundant acid fluid indicative of hypersecretion.

8. Do not make the diagnosis of hyperacidity if the symptoms occur when the stomach should be empty.

9. Do not make the diagnosis of hyperacidity in the event of the test breakfast settling into two layers, the supernatant fluid layer being twice or more the depth of the underlying sedimentary layer. These are cases of alimentary hypersecretion and not of pure hyperacidity.

10. Do not make the diagnosis of hyperacidity in cases attended by loss of appetite or by nausea or by advancing anemia or by loss of weight, especially if the patient be of adult years with or without a previously good digestion.

11. Do not make the diagnosis of hyperacidity without mental reservation in those over 45 who complain of this disorder for the first time.—*New York State Jour. of Med.*

**TREATMENT OF CARDIAC ASTHMA.**—Fraenkel (*Therap. Monatshefte*) states that in most cases of cardiac asthma, digitalis will be indicated, but until this drug improves the heart action, morphine will usually be necessary. While the effect is generally prompt, a serious defect is the necessity of constantly increasing the dose. According to A. Fraenkel an excellent substitute is heroin hydrochloride. It may be given alone or in doses of 0.005 to 0.15 Gm. or in combination with morphine (morphine



0.008 Gm. with heroin 0.004 Gm. up to morphine 0.01 Gm. with heroin 0.005 Gm.) The patients do not so readily become accustomed to the heroin and it usually is not necessary to increase the dose. Heroin also does not injure the heart; thus in one case of poisoning with 0.03 Gm. artificial respiration for two hours was necessary while the pulse frequently did not exceed 80 beats per minute. When there is extensive sclerosis of the coronary arteries and the patients also suffer from attacks of angina pectoris, digitalis may do more harm than good and caffeine should be substituted. It is a well known fact that caffeine will constrict the peripheral vessels but dilate the coronary arteries and thus improve the blood supply of the heart itself. Fraenkel has also seen good results from oxygen inhalation and vasotonin injections.—*Charlotte Med. Journal*.

**SALINE INFUSION.**—Saline infusions should be used with great care and the amount to be infused is to be determined by the effect upon the blood pressure and the heart. In some cases one or two pints of saline when infused into a vein is sufficient to raise the blood pressure and more than this may produce harmful effects; when larger quantities than four or five pints are required to restore the blood pressure the prognosis is not favorable. The infusion should be given slowly to avoid the danger of dilating the heart and causing edema of the internal organs. It should not be given faster than one liter in twenty minutes, or one-half an hour. It is contraindicated when there is distension of the right heart and venous stasis without a previous venesection. In such a case an equivalent amount of saline solution should be infused as compared with the amount of blood removed.—*Conrad George in The Physician and Surgeon*.

**DIAGNOSIS OF DUODENAL ULCER.**—Folsom gives a clear description of the symptoms which may lead one to suspect the presence of this condition. There is usually a definite history of a very uniform array of symptoms about as follows: These patients will tell you of their trouble having extended over a various number of months or years, consisting of pain or some kind of discomfort in their stomachs, coming on from one and a half to three hours after eating. This pain or discomfort usually getting worse and at times accompanied by a gaseous distention of the stomach. Almost without any exception they will explain that the pain appearing thus can be almost instantly relieved by taking some kind of food into the stomach. These patients usually go to bed with a cracker or something to eat near the bed, and usually about 1 or 2 a. m. they are awakened by the appearance of this pain or discomfort and after eating the cracker or drinking a glass of milk or even of water, they are relieved entirely and go back to sleep, not to be disturbed until the usual time following the morning meal. In addition to the hunger-pain and the relief afforded by eating they tell of persistent and recurring sour stomach, and have usually been given a diagnosis of hyperacidity, acid gastritis, etc. Moynihan goes so far as to say that "Repeated and persistent hyperchlorhydria is duodenal ulcer." To Folsom this seems extreme, and yet to disprove it would be difficult. By hyperacidity Moynihan means a subjective and not an objective hyperchlorhydria, for when those patients complain of sour, acid stomach an analysis of the gastric contents shows a hyperacidity or even

an acidity. The condition with which duodenal ulcer is most likely to be confused is gastric ulcer, though gallstones or appendicitis may cause confusion. In gastric ulcer there is the same pain or discomfort coming on after meals, but the time of the appearance of this pain is not the same. It comes on immediately or soon after the meal and is never relieved by taking more food into the stomach, but rather made worse. Vomiting occurs early rather than late, and is a more constant factor, usually relieving the pain or discomfort, and more frequently containing blood. There is, however, the same history of definite attacks, lasting from a few weeks to months, separated by interims of comparative comfort.—*Texas State Jour. of Medicine.*

**ADENOID GROWTHS IN CHILDREN.**—These growths are responsible for more of the complaints of childhood than many people are aware of. If the child suffers from an obstinate catarrh, in nine cases out of ten on examination the cause will be found to be adenoid growths of the vault of the pharynx, and, in fact, the majority of throat, nose and ear diseases have a like origin. This has been well exemplified in the report of Dr. F. Willcocks, who was sent down recently by the City of London to inquire into the health of the children at the Hanwell Schools. He found that no less than thirty out of the eighty-two examined were suffering from adenoids. A prominent pediatricist, writing on this subject makes the following interesting remarks: "Every observer must have been struck by the curious fact that the actual amount of obstruction to nasal breathing in a child produces very varying amount of symptoms in different cases. It is not by any means rare to find a boy, and a boy oftener than a girl, I think, the picture of robust health, with perfect hearing, a fully developed thorax, no excessive tendency to cold-taking, even a good runner and foot ball player, and yet with his mouth habitually open, and his sleep broken only by his school fellows' shoes and other missiles, gentle hints that he should modify his furious snoring. Such a boy is, I confess, more liable to ordinary cold-taking than he should be, and may at such times suffer from more or less deafness. Still I maintain that even these are not infrequently absent even with a remarkable quantity of adenoids. On the other hand, we know the other picture: the stooping, thin, and anemic child, undersized with contracted thorax, and deaf, always in the state of general catarrh, whether of nose, ears, or stomach, taking cold with every change of atmosphere, peevish and capricious in temper, tossing about in sleep, with voracious appetite, but easily fatigued. Such a patient may have either a large or a small amount of adenoids; the amount of buccal respiration may be conspicuous or insignificant; the snoring may be habitual or only noticed when fresh cold is contracted. And yet in the latter case, irrespective of the actual quantity of growth, operation is absolutely imperative, while in the former case the only good reason for interference would be for the sake of improving the articulation; indeed, if this is not very faulty, we should not be erring, if we advise the postponement of an operation until symptoms should arise, or if the boy is sixteen or seventeen years of age, waiting to see if nature would not take the case out of our hands by inducing spontaneous atrophy of the growths in the course of the next two or three years." We agree with the author that

in the first case operation is not absolutely imperative, but at the same time it appears that he has overlooked a rather important point; that even though a person be robust and healthy and has adenoids, that in the event of his contracting certain diseases, his chances of recovery are considerably prejudiced by the presence of these growths.—*Editorial—Pediatrics.*

THE SALVARSAN TREATMENT OF PERNICIOUS ANEMIA.—Bramwell (*British Medical Journal*) says that in March, 1911, he published two cases of pernicious anemia in which great improvement resulted from the administration of salvarsan. In this paper he proposes to record the future progress of these cases—they have remained well without any further treatment—and the results in five other cases treated in the same way. Since he commenced to treat cases of pernicious anemia with arsenic in the year 1875 he has had a large experience with the disease; the impression which has been made upon his mind by the results of the salvarsan treatment in the seven cases which he now records is, on the whole, very favorable. If his observations are confirmed by further experience, and by other observers, he is disposed to think that salvarsan will probably be found to be a more efficient remedy than arsenic given by the mouth, and indeed more efficient than any form of treatment which has as yet been employed in this very grave and intractable disease.

SYPHILITIC DISEASE OF AORTA.—Goldscheider (Wein. med. Klin.) describes his experience of syphilitic disease of the aorta, an experience which includes since January 1, 1910, 97 cases seen in private and 39 cases from the university polyclinic, of which the details were supplied by Weinberg. The cases include 42 of aneurysm of the aorta, in 15 of which there was also aortic incompetence, 25 of aortic incompetence, 28 of syphilitic aortitis without an aneurysm or incompetence, 37 of general arterio-sclerosis, 4 of affections of the heart muscles without demonstrable disease of the vessels. He says that aneurysm of the aorta when of small size is often overlooked because of inadequate percussion. Five of the 42 cases of aneurysm were also suffering from tabes. During the period covered by these observations the author was also in charge of 19 cases of aneurysm of other than syphilitic origin. The diagnosis of syphilitic aortitis without aneurysm is not always easy. Among the subjective symptoms are a sense of oppression, pressure and pain in the cardiac region, passing to the shoulder and made worse by movement, by exposure to cold air or wind, and sometimes by eating; sometimes also there is pain in the back or right half of the chest, palpitation and quick pulse with or without arrhythmia. Objectively the first sound over the aorta is impure, or there is a systolic murmur with a ringing second sound and an increased area of dullness over the aorta; sometimes general arterio-sclerosis is present, frequently increased blood pressure, and sometimes a small increase in the size of the Roentgen ray shadow. The cardiac changes are not striking, but hypertrophy and very occasionally dilatation of the ventricle may be present. The fact of syphilis was demonstrated in all the author's cases. The majority of the patients were between 30 and 55 years of age—that is, were at a period of life



in which marked arterio-sclerotic changes, other than those of syphilitic origin, are not common. The presence of tabetic symptoms is of special value for the diagnosis of the syphilitic character of aortic and vascular diseases. Tabes was present in 29 out of 136 cases, though the symptoms were often slight and might easily be overlooked. Long observation and treatment were possible only in a minority of the cases. The author's conclusions are that (1) syphilitic disease of the aorta is relatively frequent and occurs more often in men than in women; (2) the majority of cases of aortic aneurysm and of aortic insufficiency depend on syphilis; (3) syphilis is a frequent cause of diseases usually described as arterio-sclerosis; further observations are, however, needed to determine whether syphilis is the essential or only a contributory cause; (4) anti syphilis treatment of syphilitic diseases of the aorta should be much more frequently and energetically carried out than has been customary, and early diagnosis and treatment is necessary; (5) iodine treatment alone is generally insufficient. Even when iodine causes subjective improvement treatment with mercury or salvarsan is also indicated. With regard especially to syphilitic aortic aneurysm he finds (1) that specific treatment has undoubtedly a favorable effect on the syphilitic disease of the wall of the aorta; (2) a certain amount of retrogression in small aneurysms, and even occasionally in those of medium size, can be traced, and advance can to some extent be checked; (3) iodine treatment alone has not been found to have any appreciable effect upon syphilitic aneurysm of the aorta; (4) general treatment is needed in combination with anti-syphilitic treatment; (5) repetition of the anti-syphilitic treatment is indicated undoubtedly on any return of symptoms.—*Charlotte Med. Jour.*

THE DIAGNOSIS OF EYE-STRAIN.—Ellice M. Alger says that the train of symptoms indicative of eye-strain is not always as clear as the diagnostician might desire. Every attempt to observe things distinctly, and especially objects near at hand, involves more or less muscular adjustment and ocular focusing, and this, like all other muscular effort, induces proportionate fatigue. After a variable period of rest, the muscles involved regain their tone and are ready for fresh efforts, but muscles which have been exercised beyond their physiologic capacity not only tire more readily but require longer periods of rest before their tone is restored.

It is entirely possible to strain normal eyes by continuous overuse, but there are some conditions under which eye-strain is practically universal. Some neurasthenics possess such slow metabolic processes that they bear fatigue of any sort badly, and their eyes tire with corresponding facility. Ordinarily most neurasthenics suffer from eye-strain, a fact which is not only to be considered as a symptom of their general condition, but sometimes as its cause. The chief strain, however, comes from the abnormal eye, be it hyperopic or astigmatic. Such eyes not infrequently have perfectly normal vision, and the patients have no idea wherein lies the source of their trouble. It is the muscular effort necessary to the sharp vision that causes the fatigue, while the over-stimulation of tired muscles causes a long train of symptoms, sensory, motor and secretory.

Among the objective symptoms which should warn the physician of the presence of eye-strain are the elevation or depression of an eyebrow, the

formation of abnormal wrinkles in the forehead and at the angle of the eyes, the constant blinking of the eyes, and holding the head in unnatural positions in the effort to see distinctly. On the other hand many cases have no definite indications pointing to the eyes, and the physician must diagnose eye-strain from separate symptoms found clinically to be of etiologic relation, as in chronic headache. This symptom has been estimated to be present in over eighty per cent. of the cases suffering from this condition.—*Medical Times*.

THE SYMPTOMATIC VALUE OF CORKSCREW VESSELS OF THE RETINA.—Dor, of Lyon, suggests that the corkscrewing of the retinal vessels may not be simply a local congenital anomaly, but may be an acquired anomaly indicative of an exaggerated torbuosity of the vessels throughout the body. While the condition is a rare one, it is sufficient to have seen it once to always recognize it. In some fundi the torbuosity is so great as to give one the picture of the head of medusa. There is never any sign of varicosity, no adjacent edema of the retina, nor change in the appearance of the blood. No observer has ever seen this condition develop in a fundus which formerly presented a normal appearance. In arteriovenous aneurism, corkscrewing has been seen, but this was limited to a branch of the central vein. In three cases of Wagner's disease (polycythemia megalo-splenica) there was pronounced torbuosity of the veins, and a lesser one of the arteries. In leucocythemia a similar torbuosity has been observed. These observations would lead one to suspect an alteration of the blood in all cases of corkscrewing, but the findings are not such. Levin has found the composition of the blood normal in a case of exaggerated torbuosity, and the only explanation to offer is that a blood anomaly has existed and subsided, leaving the consequent torbuosity of the vessels as a permanent change. Levin thinks there may be some connection between torbuosity and hypermetropia, but this is disproved by Gloorn observing a typical case of torbuosity in a myope, and Dor in an astigmatic subject. The subjective symptoms are very slight; the subject complains of temporary obscurations, they cannot stand prolonged use of the eyes, sometimes there seems to be a pressure in the eyes, but, all in all, there is little discomfort, and the visual acuity is generally good. This would seem to prove that there cannot be any serious concomitant nervous trouble. In one case Wiebrand observed facial tic, insomnia and cardiac palpitation.—*La Clinique Ophthalmologique*.

WILLIAM SPENCER, M. D.

A CYST OF THE IRIS TREATED BY ELECTROLYSIS.—Poissonier, Amiens, made use of the electrolytic procedure which was communicated to him by Thilliez, of Lille, at the Congress of Ophthalmology, in Paris, in 1908. The patient, a woman, had received a blow in the eye, from which there was no immediate trouble. Eighteen months later pain and photophobia set in, which were not diminished by treatment. In the lower part of the iris, and pushing it backwards, was a small translucent tumor of the size of a pea. With a small irido-platinum needle attached to the positive pole the tumor was transfixed and a current of four milliamperes passed for two minutes. The cyst emptied itself, and the iris returned to its normal

position. The next day the pain had disappeared, and the iris was normal. Atropin was prescribed. A week later the pain was still absent, the upper part of the pupil dilated, less in the lower part. Three months later the condition was still the same.—*La Clinique Ophthalmologique*.

WILLIAM SPENCER, M. D.

**SYPHILITIC CHANCRES OF THE LID AND CHIN.**—The case described is that of a man twenty-two years of age, no hereditary taint, with two chancres of the face. The one on the lower lid embraced practically that entire structure. The other was situated at the outer angle of the mouth, not involving the mucous membrane, oval in shape and about 25x14 mm. The glands were swollen so that some were visible upon inspection. Date of contamination was not obtainable, but seemed to have taken place through acne pustules. Next day a roseolar eruption appeared and the "treponema pallidum" was isolated. The patient received 0.5 grm. arsenobenzol, and twelve days later a similar dose. Two weeks after the chancres had cicatrized and the roseola disappeared. The observation is absolutely classic as to the course of the disease and is cited to remark upon accidental initial lesions. The first case of the infection of the lids is a rather recent report. About one case in twenty-five of syphilis is due to an extragenital primary lesion, so the chancre of the lid becoming affected is very small. This case by having two points of entry upon the face is also noteworthy. Both improved simultaneously under treatment and were healed in fifteen days. The arsenobenzol was given by rectum, dissolved in 300.0 grains of artificial serum to which was added twelve drops of laudanum, and introduced high up by means of a soft catheter. The injections were twelve days apart. The authors do not consider syphilis with the chancres on the face as severe as infection at other points.—*Rollet and Genet, Revue Generale d'Ophthal.*

WILLIAM SPENCER, M. D.

**AN UNUSUAL CASE OF STEEL INJURY.**—The case reported was that of a boy, 17 years old, who, two years previously, had been struck in the right eye by a piece of steel which perforated the cornea and lens, but did not remain in the eye. A cataract resulted which gradually became absorbed, leaving him with a vision of 20-20 with correction. On November 27, 1911, he was struck in the left eye with a piece of steel, which perforated the upper eyelid, cornea, iris and lens. The writer saw him the following day and used the giant magnet to locate the steel, but without result. He then opened the sclera between the external and inferior recti muscles and again used the magnet without result. An X-ray picture, taken on December 3rd, showed the steel centrally located, either in or back of the sclera. Another picture was taken with the patient looking straight ahead for a few minutes, and then, without changing the plate, looking to one side. Two pictures of the steel appeared on this plate, showing that the steel moved with the eye. The eye, which up to this time had looked well, now began to show trouble. The tension diminished, the eye was painful on pressure, and the ciliary injections became decidedly marked. Search for the steel proved fruitless, the eyeball was removed; the steel was



found to have passed completely through it and was found in small mass of exudate which was attached to the eyeball. A purulent ophthalmitis had begun in the ciliary region. The scleral opening, made the day after the accident, had healed perfectly.—*Dr. Frank Allport, Ophthalmic Record.*

WILLIAM SPENCER, M. D.

A NEW METHOD OF MAKING FILM PREPARATION TO DEMONSTRATE THE PRESENCE OF GONOCOCCUS.—The author commenting on the important place the gonococcus has in ophthalmia neonatorum, refers to the difficulty of demonstrating this diplococcus, and remarks that he has been of the opinion that the methods employed are insufficient. He reports that examination on a film of epithelial cells taken from a gonorrheal patient showed masses of organisms identical in morphology with the gonococci that were found within them, the cytoplasm in many cells being completely filled. Pus taken from two cases of ophthalmia neonatorum examined in the usual way gave negative results. Films were then prepared, as used in trachoma cases, for examination of the epithelial cells. The palpebral conjunctiva was then gently stroked and the material spread on a glass slide. This was dried in the air and fixed in eighty per cent. alcohol for ten minutes, then stained with Giemsa solution, one in twenty parts of distilled water, for twenty minutes. In each case the epithelial cells were crowded with biscuit shaped diplococci. Hemoglobin agar inoculated with the discharge containing epithelial cells gave a profuse growth of the gonococcus.—*Dr. Hanford McKee, Ophthalmic Record.*

WILLIAM SPENCER, M. D.

AN UNUSUAL CASE OF EPIBUBAR SARCOMA.—Histologically the tumor did not differ in structure from a melanotic spindle cell sarcoma of the choroid, and its origin was no doubt similar—that is, from chromatophores of the corneal limbus. The duration of the case, eleven years, was apparently longer than the average duration of fatal cases of choroidal sarcomata, but it must be remembered that the latter are usually not observed until they are of considerable size. In 1903, after an analysis of most of the previously reported cases, R. G. Loring and the writer arrived at the conclusion that the view then prevailing as to the benignancy of epibulba sarcomata was erroneous, and that they were, in fact, so highly malignant that enucleation should be resorted to as soon as the diagnosis was certain. The correctness of this conclusion seems to be exemplified by the present case, as a visual demonstration to patient of the urgency of early operation, he presents illustrations, which he believes should prove most useful.

In view of the large size of this tumor, which is one of the largest, if not the largest, of its kind reported, it forms a striking illustration of the fact that epibulbar sarcomata have always a tendency to invade the globe. In the literature there are only about five cases, including one examined by the writer, in which it is highly probable that an epibubar sarcoma invaded the interior of the eye, and even in these the possibility of an intra-ocular origin of the growths cannot be absolutely excluded.—*Dr. F. H. Venhoeff, Archives of Ophthalmology.*

WILLIAM SPENCER, M. D.

INFLUENCE OF THE GONOCOCCUS IN THE PUERPERIUM.—King (Buffalo) in considering this subject says the influence of the gonococcus upon the puerperium seems to depend upon whether the infection is old or recent. Clinically cases may be grouped in those where the puerperium is complicated by a latent gonorrhœa and those in which the infection is acquired during or prior to pregnancy. To appreciate the possible effects of a latent gonorrhœa upon the puerperium one must bear in mind the influence of pregnancy. The congestion attending pregnancy stimulates the resting germs of the cervix to greater activity, resulting in a profuse discharge in the latter months of pregnancy. In such cases the effect upon the puerperium is neither marked nor uniform. Usually the puerperium is unaffected and free from fever. While such patients give no clinical evidence, there is abundant proof that the puerperium favors extension of the germs and the development of adnexal disease later. Such processes are usually chronic from the start. It is impossible to say just when such an invasion of the tubes take place, but there is every reason to believe it occurs during the six weeks involution. It is seldom that the patient has the sharp attacks of an acute pelvic peritonitis. There may be pelvic pain and distress during the puerperium or these symptoms may not appear until the woman resumes her household duties. A certain proportion of these women recover and the only evidence of their disease will be the occluded tubes. Others become pelvic invalids and neurasthenics and drag out a miserable existence.

When the infection was more recent the effects upon the puerperium are often more marked, for when the tissues are in a state of congestion as in pregnancy, they afford a most favorable field for the rapid growth of the germs. As a rule the later infection occurs in pregnancy, the more virulent it is apt to be. Two features characterize the influence upon the puerperium. The influence of recent infection in promoting other forms of sepsis during the puerperium has long been recognized. Gonorrhœal infection so changes the character of the normal secretion that almost any sort of germs will grow, as an examination readily demonstrates. Instrumentation during labor may readily result in one of the usual forms of sepsis, or a pus tube or pelvic abscess may develop. A more uncommon manifestation is septicæmia. The writer observed one such case which he describes. Lofaro has found gonococci in the blood of a large percentage of patients having gonorrhœa.—*Amer. Jr. Obs.* Vol. 65-290.

THEODORE J. GRAMM, M. D.

ECTOPIC GESTATION.—Stillwagon (Pittsburgh) in an article reviewing the much debated question of immediate, as opposed to the somewhat delayed operation, concludes that ectopic gestation in any stage is purely a surgical condition. The time of operation, in terminated ectopic pregnancy should be determined entirely by the patient's fitness to withstand surgical interference. The time of operation should be decided by a competent surgeon, each individual case upon its merits. Operation should be done at the earliest period of election. To justify any given course of procedure, a low mortality rate must be shown.—*Amer. Jr. Obs.* Vol. 65-21.

THEODORE J. GRAMM, M. D.

CHILDBIRTH IN YOUNG MOTHERS.—Bondy (Breslau) has made a clinical study of about one thousand cases in order to determine under what conditions the reproductive processes are carried out when the mother is about fourteen years and older. The essential results of his study are that the commonly accepted view is not correct, that only after twenty years or later is the woman in the most favorable time for childbirth, but rather between eighteen and twenty years of age. The physiological time appears to be between eighteen and twenty-three years. After the twenty-third year the most favorable conditions for the first labor rapidly diminish, and the unfavorable conditions of the "old primipara" appear. Labor from the fourteenth to the seventeenth year is not to be regarded as unfavorable, according to the cases studied.—*Zeitschr. f. G. a. G.* Vol. 69, p. 213.

THEODORE J. GRAMM, M. D.

ECLAMPSIA WITHOUT CONVULSIONS OR UNCONSCIOUSNESS.—Schmidt (Prague) again emphasizes the fact that while the etiology of this disease is not yet clear, it is generally conceded that definite lesions collectively characterize it. From this advance it becomes possible to classify obscure cases although all of the clinical symptoms are not present. He cites in detail the case of a woman who only had slight oedema of the extremities as the only premonitory symptom of eclampsia, and was spontaneously delivered at the beginning of the last month of pregnancy. At this time she had retention of the placenta and hemorrhage in consequence of which the patient died, without convulsions or loss of consciousness. At the section, anæmia was of course found, but in addition all the organic changes characteristic of eclampsia. So far twenty-four cases of this sort have been published, and the author believes that all cases dying during pregnancy, in labor or during the puerperal period should be carefully examined in order to determine definitely the cause of death.—*Zeitschr. f. G. a. G.* Vol. 69—143.

THEODORE J. GRAMM, M. D.

SHOULD TUBERCULOSIS OF THE KIDNEY BE TREATED SURGICALLY?—Wildbolz (Bern) has examined 139 cases who had the kidney removed for unilateral disease, and found that of 78 cases who were operated 3 years previously 58% were completely cured, 19.2% died, and 21.7% were not cured. Of those not cured only 4 were unable to work. The others showed no tubercle bacilli in the urine, but had some urinary complaints from contraction of the bladder, colon infection, etc. Of those operated in the early stage the mortality was 6.8%, while in the later stages it was 20.4%. In those operated in the early stage 76% were cured, and 52% when operated later.

The histories of 316 cases treated internally only for at least two years, 70% had died at the time of the inquiry, 99 died during the first two years of the disease, and 86 during the third and fifth year, 20 lived 6 to 10 years, one 14 years, 4, 15 years, one each 20, 25 and 30 years. Death usually followed in consequence of marasmus, uræmia or general tuberculosis.

In view of these results the author has changed his opinion that cases should first be treated internally and on this failing, should be operated,



and now advocates early operation. He believes that while deferring the early operation the other kidney becomes involved. But even after the operation the patient should submit to a general antitubercular treatment. The importance of this is shown, 78% were cured when under good social conditions, whereas only 37% were cured when less favorably situated socially.—*Abstr. Zentralbl. f. Gyn.* 1912, p. 285.

THEODORE J. GRAMM, M. D.

TEST FOR BLOOD IN THE URINE.—Leede (Hamburg) mentions the following test: About 10 to 20 cm. urine are boiled and placed upon the filter. After the fluid has passed through the filter, a small quantity of a mixture of guaiacum, turpentine and alcohol is dropped upon the filter, when if blood be present a bluish color will develop. The test fluid consists of equal parts of tincture of guaiacum and spirits of turpentine diluted with some alcohol. Urine 48 hours old still responds to the test.—*Abstr. Zentralbl. f. Gyn.* 1912, 224.

THEODORE J. GRAMM, M. D.

THE TREATMENT OF ECLAMPSIA.—Zinke (Cincinnati) says the important point in the treatment of this disease is prophylaxis. During the attacks the treatment should be medicinal rather than surgical. *Veratrum viride* in large doses is a very effective remedy to diminish the blood pressure and reduce the pulse rate. Hot baths and hot packs, free but not excessive catharsis, strict milk diet and rest in bed are all important for successful treatment. For great restlessness between the attacks chloral in large doses per rectum is effective, but the author believes that chloroform inhalations, especially if long continued tend to induce complications. The same is true of morphia, though both remedies have their advocates. Antitoxin treatment (thyroid, para thyroid extract and nephrine) promise much in this disease. Instillations of salt water or sugar water are advantageous. In the author's experience surgical treatment has not had good results. He does not favor dilatation of the cervical canal or accouchment force, but he concedes that in the presence of threatening symptoms and the failure of medicinal treatment, rapid delivery seems desirable.—*Abstr. Zentralbl. f. Gyn.* 1912, 150.

THEODORE J. GRAMM, M. D.

AN EARLY SYMPTOM OF EXTRA UTERINE PREGNANCY.—Soloway says the symptoms of an early unruptured tubal pregnancy are mostly so insignificant that they may elude the attention of even skilled gynecologists. In the very beginning of such a case it may be possible to feel a very small undefined resistance at the side of the uterus which may simulate an inflammatory adnexal tumor. The menstrual period may have been absent or not, and often there is an intermittent or continuous sanguinous discharge from the uterus. If in this decidual fragments are found there is no doubt in the diagnosis, especially when associated with periodic contracting pains in the tubes. But these symptoms are often absent, and the diagnosis is only recognized on the occurrence of internal hemorrhage from tubal abortion or rupture. The author then calls attention to an early symptom, namely an indefinite doughy resistance in the posterior

cul-de-sac. He recites two cases. In one this doughy feeling was caused by a collection of blood and the attachment of the pregnant tube to the rectum. In the other case the symptom was produced by an attachment of the omentum to the pregnant tube and the posterior uterine wall, where also a small collection of blood had formed. Of course this sign to possess full value, must be found present, after the cul-de-sac had been found empty a few days before.—*Zentralbl. f. Gyn.* 1912, p. 134.

THEODORE J. GRAMM, M. D.

THE TREATMENT OF RETAINED PLACENTAL FRAGMENTS AFTER LABOR AT TERM.—Hormann, at the Gynecological Clinic at Munich, has tested in 36 cases Winter's objections to active intervention in these cases, and concludes that Winter's assumption that the removal of placental remains is frequently followed by serious and even fatal infection even in mild cases of fever, is not confirmed by his observation. He lost no case from infection, although he does not deny that such an occurrence is possible. Winter's proposal, depending upon the fear of this occurrence, to wait for spontaneous discharge of placental fragments, appears from the author's experience cannot be carried out because in most cases serious hemorrhage calls for immediate intervention; and in the remaining cases the constantly threatening hemorrhage seems to make Winter's proposal not wise in out patient practice. Progress in the more strict determination of the indications for operating would result from a "bacterial sorting" of the cases, not only as regards streptococcus læmolyticus, but also the other pathogenic bacteria, especially the anaerobic (streptococcus putridus), of course under constant clinical observation.

In the discussion which followed the presentation of this paper, Theilhaber said that Winter's views will probably have the beneficial result of deterring some physicians from the entirely too energetic method of operating, and he believes that the use of the sharp curette and the curettement of the entire inner surface of the uterus is by no means without danger. If possible Theilhaber avoids the use of the curette and uses the finger in its place.—*Zentralbl. f. Gyn.* 1912, 52.

THEODORE J. GRAMM, M. D.

JAUNDICE OF THE NEWBORN.—Hermann (Breslau) has made a study of the blood of fifty icteric newborn children and that of fifty normal children, and concludes that icterus neonatorum is not to be classified in the pathology of the newborn, for clinically children thus affected and those who are normal are not to be distinguished as regards loss of weight, elevation of temperature, condition of the bowel movements, etc., and in no way are variations observable from which conclusions may be drawn.

The author thinks that icterus neonatorum arises as follows: Hofmeier has demonstrated in icteric children an increase in albumin metamorphosis from which he concludes that the child assimilates more than its food furnishes and hence is compelled to use up albumin from its own organs. The albumin of the blood is the first to suffer. Therefore the red blood corpuscles, and also the white are destroyed in great number, as the author has proven. Which children therefore shall become icteric depends upon the activity of their assimilation. The author believes this

to be a more plausible theory than those heretofore proposed. That eventually there may be some duodenal catarrh is not denied, but is not regarded as the primary cause. Otherwise this would correspond to jaundice in the adult, and it is not comprehensible why the blood findings here show such a difference. In jaundice in the adult the red and white cells are more numerous, the specific gravity and hemoglobin content increased, while in icterus neonatorum these are all decreased.—*Zeitschr. f. G. w. G.* Vol. 69, 165.

THEODORE J. GRAMM, M. D.

GLUCOSE CONTENT IN THE BLOOD DURING PREGNANCY, LABOR AND PUERPERIUM AND IN ECLAMPSIA. Benthin (Frankford A. M.) has studied this subject in the conditions indicated, and his tables show that glucose exists in increased quantities during labor, especially during the second stage, and diminishes during the puerperium. It may be so increased that the term hyperglycemia of labor is warranted. The uterine contractions and the increased muscular activity probably account for this increase. In eclampsia therefore, a great increase above normal was noted.—*Zeitschr. f. G. a. G.* Vol. 69, 198.

THEODORE J. GRAMM, M. D.

OVARIAN EXTRACT.—From Adler's extensive study of the physiology and pathology of the ovarian function, it appears that when ovarian extract is used for therapeutic purposes, a much better effect is obtainable from subcutaneous injection than from its administration by the mouth. It is capable of removing or improving the disagreeable experiences associated with the climaxis and following castration. This improvement, however, does not long persist. The author ascribes it to inhibition of the sympathetic nervous system and intimates that suggestion may have somewhat to do with the effects noted. A more definite and permanent effect was observed in the relief of the atonic obstipation so often seen at the climaxis—ovarian extract seems also to affect metabolism, and obesity is diminished as a result of its action. Obesity and amenorrhœa are often associated, and in this remedy we possess a means for favorably affecting both conditions, especially when conjoined with proper diet. In amenorrhœa the effect is probably due to the genital hyperæmia which Adler has experimentally proven to be produced by ovarian extract. But here again the author questions how much may be ascribed to suggestion. He points out also that a sanguinous discharge must not off-hand be regarded as menstruation, but may be the result of hyperæmia. The menstruation in which the ovaries participate, is to be determined by the changes taking place in the uterine mucosa, and these have been determined by the author in association with Hitschmann. In two cases of amenorrhœa treated with ovarian extract from whom curetted fragments were examined microscopically, the indications pointed to true menstrual endometrial changes.—*Arch. f. Gyn.* Vol. 95, 349.

THEODORE J. GRAMM, M. D.



## Monthly Retrospect

### OF HOMOEOPATHIC MATERIA MEDICA AND THERAPEUTICS

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CONDUCTED BY A. LEIGHT MONROE,

Miami, Florida.

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MATERIA MEDICA NOTES.—Ruta has helped many a time in treatment of sprains after Arnica, when from a dislocation or wrench of the tendons the legs or feet are painful with bruised feeling. The part is sensitive to touch, the knees are weak, the ham-strings feel shortened, and stepping is painful. Another most important service has been found for Ruta in prolapse of the rectum with bloody oozing, sharp pains aggravated after a difficult stool and while sitting.

Anacardium is a wonderful gastric remedy in hyperchlorhydra, eructations empty or burning, nausea with gonorhœa or pressure at stomach, cramps in the calves relieved often by lying down, but all symptoms usually better for a time by eating.

Lachesis cures a wide range in so many states at the climaxis or during septic processes, whether from the bite of a spider or the grave results of septic infection. The loquacity, amblyopia, trembling tongue, excessive tenderness of localized soreness better during menstruation, the mind worse after sleep, and the body from pressure. All this is so with Lachesis, whether the condition is a sore throat or a desperate phlebitis.

Secale in desperate abdominal states, when the pulse is rapid, facial expression anxious, tympany marked even though the bowels have moved freely; restless, with desire to throw the covers aside; the picture is one of intestinal paresis and Secale 3x has oftentimes brought recovery. It is pathologically and therapeutically indicated.

Colocynthis is a frequent prescription for the pain so characteristic whether it be in the abdomen or an extremity, with its paroxysmal acuteness, during dull continuous suffering. The abdomen, often distended, is always relieved by passing flatus, drawing the limbs up, worse by pressure and pain generally centered about the navel.—*North Amer. Journal of Hom.*

MEDICATION DURING PARTURITION.—If there is any remedy in our armamentarium to which the adjective principal may be applied, it is pulsatilla. This drug, in its pathogenesis typifies a certain well understood type of woman who, no matter what her illness may be, seems to demand at some stage at least, the exhibition of this polychrest. Sensitive, fickle, changeable, easily depressed, shedding tears upon slender provocation, the pulsatilla woman bears the irregular pains of labor

badly and these are strengthened and made more effective by a timely dose of the remedy. During the puerperal period, if necessary for any reason to diminish the secretion of milk *pulsatilla* will be effective.

*Caulophyllum* is of value in developing true labor pains where these are spasmodic, flying in all directions, but doing no effective work. The os uteri is spasmodically contracted.

The woman of rigid fibre, strong and plethoric, whose pupils are unusually large, whose face is exceptionally flushed and in whom pains are remarkably severe, coming and going with undue suddenness, demands *belladonna*. Vaginal examination detects a hard, rigidly contracted cervix, the vulva hot and dry. During the puerperium a sudden rise of temperature with the facial aspect already described, no matter what the cause, a threatened mastitis with the breast rosy red, tender and hot, demands this remedy.

*Gelsemium*, the yellow jessamine, typifying as it does the sluggishness of southern climes, finds a useful field during labor. With os contracted, the sleepy woman, face dark-hued and of dull expression is disturbed by pains which shoot up the back or extend to the hips. Again, the pains may be entirely absent, an atonic state prevailing, with os widely dilated and a condition of total inaction present. The pulse is quite in keeping, being soft and weak. Where fever is present, absence of thirst is characteristic.

*Secale cornutum* is seldom used in potency by physicians, but commonly employed in fluid extract, tincture or more powerful preparation of the alkaloid, for its so-called physiologic effect, during or after the third stage of labor. Its use here is empirical and routine and not based upon the law of similars. Homoeopathically the remedy suits thin, scrawny women in whom the pains of labor are irregular, ineffectual, spasmodic, weak or even entirely wanting. Postpartum hæmorrhage of black blood, worse from the slightest motion; symptoms of collapse with desire to uncover.

When, during the third stage of labor, the woman grows pale and bluish about the mouth and eyes and complains of nausea, the timely administration of a dose of potentized *ipæcac* may prevent hæmorrhage. If the latter be present, the blood is bright red, profuse and clotted. The breathing is heavy and oppressed.

After long, difficult or instrumental labors, the patient is apt to experience difficulty in voiding her urine and to complain of great soreness of the abdomen and vulva. If so, *arnica* relieves these conditions very promptly.

Where the difficulty with the bladder is of a semi-paralytic nature, the result of long retention, with frequent and urgent desire, *causticum* is demanded instead.

For the atonic constipation which is a frequent accompaniment of the puerperium, with total inactivity of the bowels as shown by absence of desire for stool, a few doses of opium will arouse a normal peristaltic action of the intestines and enable a simple enema to produce a copious stool.

During the first stage of labor, where the os is rigid, where pains are strong, but badly placed, often shooting from side to side across the abdomen, with nervous rigors or "shivers," *cimicifuga* is indicated.

In the latter part of pregnancy, where false pains are troublesome, it may be very useful also.

Any list of remedies likely to be of service during or immediately after parturition may admit of almost indefinite extension, since almost any remedy, theoretically at least, may be called for. Here as every where else, the patient and not her disease is to be prescribed for; the uncommon, peculiar and characteristic symptoms are those to be selected by the physician as his guides to a correct remedial choice. No attempt has been made in this essay to give an exhaustive list of remedies or symptoms, but simply to present those more frequently demanded and of known reliability in action.—*Med. Advance.*

TREATMENT OF MODERATE CONFIRMED DIABETES—(1) *Alimentary.*—What has been hitherto aimed at is the suppression of sugar-producing substances in the diet, and in the case of an obese patient this may be carried out with a certain amount of rigour, much as such a patient dislikes his starchy and saccharine food being cut off. Even in such patients, and a fortiori in patients of the lean type, complete suppression is not now carried out, for in the case of the latter our first care must be that he does not lose weight. Dieulafoy has rightly said: "It is mischievous, by too strict a regimen, to try and cause the total disappearance of the glycosuria." The sugars known as pentoses, e.g., levulose, do not pass sensibly into the urine, and may be allowed in moderation where expense is not an object. Inuline, which is contained in many vegetables, changes into levulose, not into glucose, and the vegetables containing it are those which are most suitable in drawing up diet-sheets for the diabetic. These vegetables are artichokes, Jerusalem artichokes, salsifie, French beans, salads, leeks, and mushrooms.

Instead of bread, the potato is now frequently given, and I have for years past been prescribing it with considerable satisfaction. The quantity ought not to exceed 100 grm. at each meal or a total of 500 grm. per diem (equal to 100 grm. of carbohydrate) and, if necessary, this quantity is cut down until the patient is aglycosuric; it may then be cautiously increased until sugar again appears in the urine. Rothery, who has written upon the "potato cure," questions whether the effects ought not to be ascribed, in some measure, to the large amount of potassium salts contained in the potato, and looks upon the potato as a convenient means of administering alkalies.

In addition to the aforementioned list of vegetables, I prescribe greens, spinach, cabbage, sprouts, cauliflower, tomato or radishes, up to 10 or 12 ounces daily.

Van Noorden was the first to advocate the routine use of oatmeal, and he gives 250 grm. daily, either as gruel, porridge or oatcake, with the addition of 20 to 50 grm. of butter and one or two eggs. Levy finds that patients do better on oatmeal alone than on oatmeal in addition to strict diet. As I have never used it to the exclusion of other articles of diet, I cannot speak from experience. Certain it is that oat-starch does better for patients than other starches.

In the matter of albuminous and fatty food we may allow our patient from  $\frac{1}{2}$  lb. to 1 lb. of meat, two or three eggs,  $1\frac{1}{2}$  to 4 oz. of cheese, and the same of butter, bearing in mind, however, that the ingestion of



excessive quantities of fleshy or fatty food is liable to lead to acidosis and coma. To those who are accustomed to the use of alcohol half a pint of light dry wine may be allowed daily in preference to spirits. In whatever form it be prescribed, alcohol must be used with the greatest circumspection. It certainly stimulates the combustion of glucose, but we must be careful lest by its abuse we bring on cirrhosis of the liver, to which diabetics are particularly prone.

The amount of physical exertion allowed to diabetics requires careful regulation, for the diabetic has to reckon with the functional capacity of his myocardium, which threatens him with cardiac collapse.

Turkish or Russian baths, even to those accustomed to their use, are best forbidden lest nervous accidents of a grave character occur. Long railway journeys, too, especially in hot weather, such as to Vichy or Carlsbad, are to be avoided. In mild cases of the obese type I have seen a course at Carlsbad do wonders; at the same time one cannot help feeling that the beneficial effect of such cures is very largely the result of the adoption by the patient of a rational system of eating and drinking, and of the general habits of life, and that his ultimate fate depends upon his carrying such rational habits into his ordinary life.

**DRUG TREATMENT.**—The old school has little to offer us now that is not at least as old as my student days. Opium and its alkaloids, morphia and codeia, still remain the standing remedies with most writers, especially codeia.

Aspirin and the salicylates in doses of gr.x to gr.xv three or four times a day have lately been much lauded by Williamson, but few other observers have had the success which he seems to have obtained.

Van Noorden finds jambul of service in some mild cases. This drug, given empirically, was introduced to our notice by the late Dr. Dudgeon, and in alimentary glycosuria it appears to have an undoubted effect; given in genuine diabetes I have never seen the least help from its use. Nitrate of uranium (also well-known to most of us) has been given by West in doses of gr.xx ter die, with apparently good effect; but other observers do not bear out his contention.

Bicarbonate of soda in quantity ranging from 6 to 20 grm. per diem is largely prescribed at the present day with a view of staving off the incidence of acidosis and coma.

Arsenic, and tonics generally, are praised.

Opothrapy, in the shape of liver extract and extract of pancreas, has been used, but I have but little first-hand knowledge of them. The occasional use of pancreatin has not in my hands been followed by very striking results. High-frequency currents have been used in diabetes, but, as in so many other conditions, their use has fallen off most lamentably.

In our own school the two principal drugs quoad the glycosuria are undoubtedly phosphoric acid and nitrate of uranium, although in looking through the records of cases said to have been relieved or cured by them, one is speedily convinced that a large number of these are cases either of intermittent or of symptomatic glycosuria. All I can say myself in the matter of the drug treatment of genuine diabetes is that in the obese type of patient, if not very young, these two drugs, coupled with suitable regimen, have frequently enabled me to keep the disease at

bay for many long years, indeed the patient has usually died of something quite unconnected with the diabetes. In the more common type (the diabète maigre of the French) with the same drugs I have been able to hold the disease in check and stave off for a time the inevitable dénouement.—*J. Galley Blockley, British Hom. Jour.*

**REMEDIES IN ANGINA PECTORIS.**—Arsenic is probably the most reliable remedy. Hartman says "not only the actual paroxysm, but the disease generally finds in arsenic its appropriate remedy, provided the disorder is not complicated by structural changes in the heart and large arteries." "It is indicated if the patient is compelled to breathe gently, stooping forward, and if the least motion causes a complete loss of breath, if oppression and stitches in the precordial region are associated with anxiety and a fainting sort of weakness; if the breath gives out even while the patient is getting out of bed and if it takes him a long time to recover his breath; or if the paroxysm is started by a simple change of position in bed." To these indications Hale adds, "regularly recurring paroxysms as sometimes occur in malarial districts."

Lachesis and naja are useful when the pain and dyspnœa are concomitants of organic disease of the heart, causing distressing sensation of choking, constriction, or rising in the throat and inability to speak. Hale uses the 200 and repeats not oftener than every twelve hours.

Aconite is an excellent remedy if the cases are marked by intense anxiety, fear of death and cold sweat, fever pulse, intense pain in all directions and general or local numbness and tingling. It is indicated more often in neuralgic cases.

Spigelia has been used with good results when there are severe stabbing stitches in the heart at every beat, pain and palpitation aggravated by bending forward, touching the stomach, lifting the arms, or any other motion. It is especially indicated if the trouble is of neuralgic origin and also in cases of organic disease.

Rhus toxicodendron is indicated in patients of a rheumatic tendency with or without organic disease. Characteristic indications are, stitches in the heart with painful lameness and stiffness of the whole body and extremities, and pain extending down the left arm. A case having these symptoms, also hypertrophy with dilatation, paleness and weakness, pulse soft, slow, 48 per minute, coldness and numbness of the left arm, pain worse every morning at 4.00 o'clock, a faint, fluttering sensation in the stomach and left chest, gurgling in the region of the heart, soreness throughout the left side, severe palpitation brought on by lying on the left side, is reported as cured by rhus tox. 200.

Phytolacca will be indicated in those cases where the pain extends into the right arm.

Dr. Hale cured a case with cimicifuga; the pains were sharp, lancinating and extending all over the left chest, down the left arm and into the back, with dyspnœa and unconsciousness.

If the foregoing remedies fail to cure, some of the following may be of service: Cuprum, crotales, arnica, cactus, laurocerasus and valerianate of zinc.—*C. P. Bryant, M.D., Pacific Coast Jour. of Hom.*

**REMEDIES FOR FUNCTIONAL DISORDERS OF THE HEART.**—The mildest form

et the disorder when it arises from fright or undue exertion usually needs only rest of mind and body. For paroxysms of palpitation from physical excitement, mental emotion, etc., a single dose of aconite will suffice if it has been caused by fright; coffee if from excessive joy; ignatia if from sudden grief, and scutellaria if from inordinate excitement of other kinds. For paroxysms of tumultuous and irregular beating of the heart with violent impulse, the chief remedy is veratrum viride. Such paroxysms usually occur in plethoric subjects. In similar cases cactus is often indicated. For paroxysms characterized by irregularity and intermissions with feeble action of the heart, another class of remedies are indicated, such as digitalis, cannabis indica, laurocerasus, hydrocyanic acid, arsenic, veratrum album and aconite. Hysterical palpitations require the use of ambra, asafetida, camphor, castoreum, crocus, ignatia, lilium, sumbul, scutellaria and valeriana.

*Nux moschata*.—Here the most prominent symptoms the quivering, trembling, fluttering and violent palpitation, labored beating of the heart and a fearful embarrassment. It is asserted to be curative in cases arising from fright, fear, grief, stoppage of urine, uterine troubles, menstrual difficulties, especially indicated in delicate nervous women given to fainting or sensitive to the slightest emotion and when the cardiac condition alternates with uterine or vesical disorder or even gastric trouble.

*Digitalis*.—Great weakness in the chest, shortness of breath, suffocative constricted feeling in the chest, anguish in the region of the heart with or without palpitation; worse from exercise of the body, worse from mental emotion, fear if he moves will cause heart to stop beating.

Gelsemium is the opposite of digitalis in that the patient must move or the heart will stop beating, and is worse when thinking about his trouble; heart's action slow and feeble; chills with pain in the head; cold hands and feet.

*Aconite*.—Great anxiety, fear of sudden death, violent palpitations, full bounding pulse, lies on the back with shoulders raised.

*Coffee*.—Due to excessive joy; strong quick pulse, with sleeplessness.

*Ignatia*.—Caused by sudden grief: anxious feeling in the precordia; constriction at the heart; disposition to cry and to sigh.—C. P. Bryant, M.D., *Pacific Coast Jour. of Hom.*

STUDENTS OF MEDICINE DECREASING IN UNITED STATES. The number of persons studying medicine in the medical colleges in the United States has decreased steadily since 1903, according to the annual report of the Council in Medical Education, which appears in a recent number of the *Journal of the American Medical Association*. In 1880 there were 11,826 medical students in the United States, in 1890 there were 15,404, in 1900 there were 25,171, in 1904 there were 28,142, in 1912 there were 18,412. This is the smallest number of medical students in the last twenty years. Of these, 17,277 are in "regular" schools, 827 in homœopathic and 308 in eclectic schools. The total number of graduates in medicine in 1912 was 4,483, an increase of 210 over 1911, of 43 over 1910, but a decrease of 32 when compared with 1909 and of 1,264 when compared with 1904. Of these graduates, 4,206 were from regular schools, 185 from homœopathic and 92 from eclectic schools.



# THE HAHNEMANNIAN MONTHLY.

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## THE RELATION OF PATHOLOGY AND DIAGNOSIS TO THE HOMŒOPATHIC PRESCRIPTION.

BY

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THE past decade has seen such wonderful advances in pathology and pathological technique, with its corresponding advance in instruments of precision and diagnostic technique—the surgeon with the advancement of abdominal surgery has shown us the exact tissue changes which accompany certain symptoms—the advent of the serums, vaccines, etc., in the treatment of various pathological conditions have all worked to the end that members of all schools have given to pathology and diagnosis the highest place and have made it a basis for their therapeutics.

Some of our prescribers, the writer among the number, are still old-fashioned enough to believe with Hahnemann that there is a more stable basis for our therapeutics than pathological findings; but when we try to express our beliefs in the societies the impression seems to be taken that this small group of homœopaths have no use for diagnosis and are trying to deride and belittle the great advance of pathology. This is an entirely wrong impression and one far from the truth. The prescriber rejoices with the surgeon, pathologist, bacteriologist and the diagnosticians in the advances of their knowledge, but he puts this knowledge to an entirely different use than those who use it for a basis of their therapeutics.

To know symptoms in cause, beginning, purport, direction

and ending is only that acquaintance with sickness so often urged by Hahnemann. To distinguish the symptoms that are natural or common to fixed morbid states should be the earliest acquirement of the physician in order that he may learn to discover what is peculiar and unaccountable. Let it not be supposed for one moment that these pathological diagnostic symptoms that are predicated of the disease are to be ignored or considered valueless in selecting the remedy, but that they are to be considered subsequently to the individualizing symptoms of the patient.

Those that were privileged to know Hahnemann and his methods of working knew him to be one of the most careful diagnosticians of his time. All that was known of pathology and the results of tissue changes he had mastered; yet he did not use it as a basis for his prescription. It was my good fortune to know one of Hahnemann's patients and he often told me that Hahnemann gave him a more thorough and vigorous physical examination than any of the noted physicians of Scotland and England. With the knowledge that Hahnemann was an expert diagnostician, that he did make his diagnosis and tried to arrive at the pathological tissue change present in every case we find this statement in his *Organon* concerning those men who are always trying to remove the cause and making pathological symptoms the basis of their prescription. "Hence I cannot conceive how it is possible to go to the bedside of a patient and without carefully noting the symptoms and being governed by them to seek for the object of treatment in the obscure and invisible interior of the case." Hahnemann or any of his followers have never objected to the use of the knowledge of pathology in its proper sphere; but we have objected to its use as the basis of a prescription. We must have something more than pathological findings, something more than the results of disease upon which to base our prescription. The physician who can only see the diseased organ; who can find only the symptoms common to the disease and who bases his prescription on pathological findings can never hope to obtain success for the reason that the provings of remedies have never been pushed that far. The provings have to do with the conditions preceding pathological tissue changes: they deal with the innermost changes of the patient where there can be no tissue change to account for the symptoms. Here I know will come the question of reproving the *materia medica* so we will

have evidence of pathological changes produced by the remedies. Taken for granted that we could find the provers who would submit to the drug being pushed to its pathological end; where, as the results of the diseased or deranged vital force, we would have such changes as would denote cancer; how better off would we be? How much would we have gained? Certainly we should know that this remedy produced such an end product of disease but how would we know that many others would not do the same? How would we know that we had the only remedy which would produce this condition? We could only know that this remedy would cure or be homœopathic to those cases of cancer which were the result of the same symptoms in our diseased patient as those which were produced in the provers before our end product was discernible. In other words, we would not be any further advanced than now. If the pathological tissue changes have not advanced so far that the language of nature, as expressed in the particular and general symptoms of the patient, is hushed; we may find a curative remedy among the drug disease picture in our materia medica as it now stands.

In quoting from a paper read before this society, in 1863, by Carroll Dunham, we find he expresses the results or the practice of prescribing on the pathological findings in the following terms: "Those of our school who insist upon pathology as a basis of therapeutics, who look upon the single objective symptom and its nearest organic origin as the subject for treatment, and who deride the notion of prescribing upon the totality of the symptoms and claim to be more than mere symptom coverers, in that they discover and aim to remove the cause of the disease,—these colleagues are as false in their pathology, according to the highest old school authority, as they are faithless to the doctrines and impotent as to the success of the founder of the homœopathic school. Hahnemann condemns this practice in his *Organon*, in the following words: "Every physician who treats according to such generalities however boldly he may assume the name homœopathist remains neither more nor less than a generalizing allopathist, since homœopathy is absolutely inconceivable without the most precise individualization."

The man who uses his homœopathic remedies in this way cannot expect better results than his allopathic confrere. It is to this great abuse of pathology that we homœopaths object



and has led to the assertion that better homœopathic prescriptions would be made without a diagnosis—not because the pathology and diagnosis has no place in the symptom picture, for it has, but from the fact that so many let the diseased organ, the pathological findings and the diagnosis obscure and overshadow all else.

This must be remembered: That symptoms when it comes to prescribing for a case constitute the whole basis for a prescription. There is no other way. We may theorize, use the microscope and other instruments and methods of diagnosing as much as you like; but when it comes to the actual application of the remedy the symptoms must be the only guide. The homœopath's purpose is to transfer a man's sickness to paper and to find the image of the sickness in the *materia medica*.

Diseases must be brought out in symptoms with the end in view of its becoming some likeness in the *materia medica*. Some of the symptoms you find will have reference to pathology and diagnosis while others will have reference only to the *materia medica*. If the image secured is complete it will include all these symptoms. The physician must judge these symptoms and determine which are common to the drugs and disease and which are peculiar to this particular case of disease. It is here that pathology and diagnosis render the prescriber the greatest aid.

Thus far I have laid particular stress on the relation pathology should not bear towards the prescription and now I shall endeavor to show how it can be used in the symptom picture which goes through the process of individualization that it may correspond to the pathogenesis of some remedy as found in our *materia medica*.

This, as in other matters, has been much easier to tell how not to do it than to present in a logical way the methods of its use to the prescriber. As we look over the best of our homœopathic literature we are struck with the fact that the material contained tells how not to do lots of things, that it shows results produced by the use of certain measures but does not produce a logical explanation of the methods or give any definite, clear-cut rules for their duplication. If one wishes to comprehend the logic of their work he must not only have a mind trained to reason but must spend much time in reading Hahnemann's writings and meditate upon their truths. When one comes to impart this knowledge to others he finds before

him an extremely difficult task as it is rather like trying to explain a geometrical proposition to one who is not familiar with algebra. No doubt that fact will account for the dearth of logical explanations in our literature and especially upon the subject in hand. After careful search through all the homœopathic literature from the writings of Hahnemann until the present day, I could find little or nothing which bore upon the subject; with the exception of scattered thoughts throughout Kent's lectures on Homœopathic Philosophy. From the previous portion of the paper you will observe that we have tried to show that we must ignore pathological changes when choosing the remedy, yet a knowledge of true pathology is absolutely necessary and we find that it has the following eight uses for the prescriber:

First. It is only through this knowledge that we may understand the course and progress of the case.

Second. By it, we know in certain cases or at certain stages of diseases that no matter how similar the symptoms of the patient may appear to those produced by some remedy, that owing to the superficial character of their action, they cannot prove curative. For example, in tubercular phthisis the symptoms might call for belladonna, but its action will not cure this condition. In pneumonia, at the stage of exudation, the symptoms might apparently call for aconite; but we know that that remedy cannot produce such a condition, and upon closer examination we will find that some deeper acting remedy, such as sulphur or lycopodium, is needed. (Here you must not think that I am advocating the administration of some other than the remedy for the totality of the symptoms. In this case sulphur is the chronic of aconite and many of the symptoms have a close relation such as the restlessness, the burning, the tingling sensations, the flushed face, etc.)

Third. Pathology enables us to decide, as new symptoms arise, if these symptoms can be accounted for by the natural progress of diseases or to the action of the remedy that has been administered. For example, if we give a remedy for meningitis and there develops an eruption on the skin and the mother will tell you, "That is the same skin trouble I have been trying to cure so long and have just succeeded in driving it away, now it has come back." You will know from the disease that such would not be the natural progress but that the eruption has been thrown upon the surface by the action of the

remedy and that you must let it alone. If you are treating an old case of endocarditis and a rheumatic swelling of the joints appear you will know that this is not the natural progress of the endocarditis, but that your remedy has brought back an old symptom which existed prior to the endocarditis and that you must not interfere with the action of the remedy. Perhaps you have been giving belladonna for some days or weeks in oft-repeated doses and your patient develops a throbbing headache, a scarlet rash, a sore throat, and a full, bounding pulse. Do not think you have a case of scarlet fever, but stop the remedy and see if the symptoms do not disappear.

Fourth. One thing you must ever keep in mind, that is: The patient is curable and not the disease. In this we are liable to error if we have not a proper understanding of pathology. We must realize that when there has been sufficient pathological change to result in destruction of tissue or an organ, that it is beyond the realm of medicine to cure: or that when new tissue has been formed, such as tumors, we may relieve all distressing symptoms of the patient, but the tumor mass will remain and the surgeon must remove the mass if we wish it to be removed. In case of a long-continued inflammation of a joint where ankylosis has taken place: our remedies may have removed all painful symptoms but it will be powerless to break down the adhesions, and other methods must be employed.

Fifth. Pathology also helps us to know what is curable and what is incurable in disease, and after the use of our remedies has confirmed by their action that the case is incurable with medicine we must look to the surgeon and see if he can offer any hope by his mechanical interference.

Sixth. Pathology also teaches us that it is dangerous, at times to administer the apparently indicated remedy, I say apparently indicated, for I believe that when we know from the pathological symptoms that a remedy, although it may completely cover the symptoms, will produce a speedy death it ceases to be the indicated remedy in all that the name implies. For example, if we have an abscess walled off about the appendix we know that nature's only method of cure would be to point the abscess and in that way evacuate the pus. If we gave silicea and forced nature to do that, we would be committing a grievous mistake. If, in the advanced stages of phthisis, we gave a remedy to hasten nature to relieve the system of this material by suppuration we would hasten the patient's end.



Seventh. Pathology, through its interpreter, diagnosis, helps us to determine how much of the diseased condition is due to unhealthy surroundings, habits, physical excesses, etc., which can be cured wholly or in part by hygienic measures and without these adjuncts to our therapeutics we might give a remedy indefinitely without resulting cure.

Eighth. Through our knowledge of pathology we are enabled to distinguish those symptoms which are common to that special state of disease and hence those that are peculiar to this patient. It is this particular knowledge of pathology that helps us in the individualization of our symptom picture and hence is of the greatest importance to the prescriber. So far as there is a morbid anatomy which can account for symptoms, so much less are those symptoms worth as indicating the remedy. If you had no other symptoms you could not find a suitable remedy. Those symptoms which are common to every disease are not to be recognized as having a place in your individualized symptom picture, for they lead to no curative remedy.

Cancer has many symptoms which are common to that disease—the burning, stinging pains; the indurated glands; the hardened tissue; the peculiar cachexia; the lead colored tongue, etc., are all diagnostic of the disease, but are of no value in finding a curative remedy. The diagnostic symptoms and the pathology are thoroughly understood but they have not helped in finding a remedy which is curative. With all the advancement in the pathology and diagnosis of this disease there have not been any more cures for the reason that these symptoms and the pathology are not the disease but the results of disease, and when tissue changes have become so far advanced that the common diagnostic pathognomonic symptoms have overshadowed the general and particular symptoms of the patient, then your case will be incurable.

The common symptoms of typhoid fever are the general malaise, epistaxis, the peculiar temperature wave, gurgling and tenderness right iliac fossa, rose spots, early dirotic pulse, enlarged spleen, Widal reaction of the blood, Diazzo reaction of the urine. These symptoms you use to make your diagnosis—you expect to find them in every case, but among these are none to lead you to your remedy. You may give baptisea, bryonia, gelsemium or what not on these symptoms, but if you have no general or particular symptoms to guide you to your remedy, you will have done your patient no good. If your typhoid

cases run the full four weeks you may rest assured you have done nothing to help them. If we give bryonia we must have the particulars which individualize it, and make it a bryonia fever: such as the splitting headache, worse from motion or on opening the eyes, irritableness, great thirst for large quantities of water, dry, parched lips, delirium at night about the affairs of the previous day or business matters, wants to get out of bed and go home, and so on, we might give a long list of symptoms which would make it a bryonia case. In our cases where baptisea will be curative we must have besides the diagnostic symptoms those particular symptoms which are characteristic of the remedy alone.

All through the list of diseases the diagnostic symptoms will be found of no value on which to hang a prescription. The more accurate the diagnosis and the more substantial its basis, the more inaccurate the prescription that is based upon it. It must be understood that the diagnosis does not reveal the nature of a disease in a manner to image a remedy. The diagnosis is the name of ultimates and exteriors, while it is the inner nature that must be perceived through the peculiar characteristic signs and symptoms in order to discover the remedy that will cure. It has often occurred that a remedy has made brilliant cures when it suited the individual patient, even though it was not known to possess a strong likeness of the disease. To illustrate this point, will give a case of gall stone colic which was cured by chamomilla:

Miss G. C., aet. 36. History of gall stone colic six years' duration. Attack every three weeks. Stones found in stool. Besides all the diagnostic symptoms of biliary calculi the following individualizing symptoms were present: Pains seemed unbearable, seem as if they would drive her mad, cross, irritable, peevish, does not want anyone near her or to be spoken to during the attack. Epigastrium painful, bloated, eructations painful, worse morning; smelling like spoiled eggs, eructations aggravate the pains, pressure in stomach as from a stone. Profuse yellow leucorrhœa causing smarting in vagina and vulva. Muscles in small of back feel bruised and sore as if they had been pounded. General aggravation from heat—sensitiveness to cold air, dreads cold winds. Chamomilla 500th one dose. No more attacks to date; all symptoms have disappeared—mental condition changed, skin cleared, gained in weight. In fact, she says she has not felt so well in ten years.

Pathology has taught us that we can remove the symptoms and diagnostic signs of disease when we have found the remedy for the sick patient no matter if the signs say diphtheria, typhoid fever, small-pox, syphilis or whatever it may be, if the case is curable. Pathology has given us confidence in our remedies so that whatever may be the local name of the disease, whatever pathological name it may bear, if the general symptoms correspond to those of a remedy we do not hesitate to give that remedy and expect a cure if the case is curable (exception as stated under number six). When conditions arise that are incurable they act as the best of all measures to palliate and ease the sufferings of the end.

The later developments of pathology show that cures take place by creating in the blood new opsonins and other antibodies; these in turn raise the anti-bacterial power of the blood, the protective forces against living bacteria are increased and thus diseases are cured. If there is any truth in the law of similars how absurd it would be to try to explain their action by pathology. All we can do by any means we may use is to stimulate the vital force. No matter by what means we try to accomplish this end, nothing more can be done. This fact again brings before us the fallacy of pathological prescribing.

Taken for granted that the new tenets of pathology are habitable—and we know the law of similars to be true—then let it suffice that without any further attempt at explanation we assume the remedy acts in this manner more easily, surely, quickly and in a more gentle manner than any other means.

In conclusion, I wish to leave the following thoughts with you, that is, let us look to diagnosis and pathology, let us perfect ourselves in these branches and equal or excel our brothers of the old school. Let us be able to name disease. Let us use all the known means of our laboratories and diagnostic methods to prove to the skeptical that we can cure these conditions with the homœopathic remedies; but do not let this chase after diagnostic symptoms and pathological disease endings lead us to desert our law of therapeutics. Do not let these things lead us to the stand of the old school where we say there is nothing in medicine.

Further investigation will increase our knowledge and broaden our views of the pathology of disease; but do not let us try to make the quick-sands of an imperfect ever-changing pathology the basis for our practice or a stable therapeutics. The law



of similars points to a better way, a natural method of cure and an unequalled success is assured to those who follow it, not to those who simply believe in it, but to those who obey its every mandate.

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## THE EVOLUTION OF THE SUICIDE.

BY

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(Read before the Southern Homœopathic Medical Association, Richmond, Va., October 17th, 1912.)

SELF-DESTRUCTION as a means of departing from life is no new invention, yet to it there always attaches something of novelty from the fact that, in a large proportion of cases, it is difficult to say with certainty just what the combination of mental processes was that led to this step, so final and irrevocable. Upon the existing cause we can often lay our finger: it is what lies beneath and back of it all, that has a special and peculiar interest for the thoughtful mind.

If the voluntary taking-off of individuals were diminishing, we might consider the subject of minor importance; but it is a matter of comment in most civilized countries, that suicide as a *dernier resort* is, as it were, becoming popular. It is also increasingly noted that, like many other things in this world, it has to a considerable extent departed from its original simplicity, and exhibits a degenerative change more formidable by far than its early primitive character.

The Brahmin and the Buddhist, believing in the doctrine of transmigration and many reincarnations before the attainment of eternal joy or rest, eagerly availed and still avail themselves of slight pretexts to achieve a shortening of these successive life stages by voluntary exits, such as burial alive, precipitation from great heights, or drowning in some convenient holy river in that India so far away to us; or drowning, hanging, hara kiri or disemboweling, starvation, etc., in China and Japan. However sternly forbidden, yet most of these practices persist to the present day. It is true that the wheels of the car of Juggernaut may no longer roll, and Suttee no longer be performed, but where there is the will, the ways of escape from the physical body are not thereby sensibly diminished.

The Egyptians considered suicide an honorable death, and it was commonly resorted to among them. The Jews often preferred suicide to slavery. While among the early Greeks suicide was rare, and, except as an act of patriotism, thoroughly reprehended, yet, with the rise of the philosophic school, the Sophists, Cynics, Stoics, and of the pleasure-loving Epicureans, individual liberty to live or die was conceded, and self-destruction often lauded as a noble and courageous act.

The doctrine of the German pessimist Schopenhauer, centuries later that, when a man finds himself hard pressed by the ills and sorrows of life, it is both right and wise of him to escape therefrom by his own voluntary act, was already theirs; and even the negative condition of boredom, or *tedium vitae* was reason enough to their thinking for quietly stepping off the stage.

It may here be pointed out as the real meat of the matter as it relates to the present discussion, that reason was, in the main, the distinctive feature of suicide as it existed among the ancients, with one or two exceptions which will be duly noted.

The Orientals wished to escape unbearable pain, or incurable diseases such as leprosy, and deliberately chose death. They offered themselves, also by choice, as human sacrifices; much as the Christian martyrs, frequently self-elected, did later. Religious fanaticism may be cited as one of the two conditions which might be classed as irrational. This may be true in instances, but the viewpoint and enlightenment of the past was incalculably different from that now obtaining. Self-destruction from religious fanaticism amid the civilization of the twentieth century in Christian countries to-day, is necessarily far removed from similar suicides in centuries gone by, based on the reasoning and assent, if not approval, of large numbers of the individual's associates.

Reason, then, and simplicity of motive marked these early suicides. Religious fanaticism, pain, and incurable disease were simple reasons, sustained to a considerable degree by public opinion, as also was the fear of slavery or dishonor at the hands of enemies. When Samson ingenuously pulled down the temple upon the Philistines, his object clearly was revenge; and when Saul and his armor bearer fell upon their swords, they merely preferred death to capture.

Empedocles, jumping into the crater of Etna, that by his mysterious disappearance his admiring constituents might

deem him even a god, and Cato, stabbing himself to prove one man at least free under Cæsar's dominion, were reasoning if misguided beings.

The hardy Norsemen and barbarian Goths brought up to believe that violent death in battle or even at their own hands, would bring them more honored to Valhalla than a natural decease, had reason on their side for prematurely cutting short their existence. And the old and ailing were frequently carried to battlefields at their own request, on the chance of being dispatched in the excitement of the scrimmage.

One exception to this justifiable inference of rational suicide as the rule among ancient peoples, we may advisedly make as we consider how these cases were multiplied in the days of Rome's deterioration. As the early Roman characteristics of virility and temperance were overlaid and finally supplanted by effeminacy, gluttony and licentiousness, so the suicides the outcome of degeneracy, were necessarily other than those attributable to primitive and uncomplicated causes. These examples of Rome's decline stand, as it were, as the most conspicuous forerunners of a class of cases which form, probably, the largest proportion of the increasing number of suicides to-day, suicides characterized above all else by defective mental stamina.

It is not necessary to prove these self-destructionists insane. It is not the fact of insanity, *per se*, that is the great threat to our boasted social advance. To a considerable extent we take care of the insane, especially the insane determined to commit suicide, and so irresponsible that to allow them to carry out their uncontrollable impulse, would be to burden them with no culpability in the sight of God or man. This blessing of extinction, however, we sedulously deny them, in accordance with the refined if cruel sentiment of the age.

But before examining the evolution of these and other cases of suicide, it may be well to see if we are justified in making the statement that they are increasing. The old objection is offered that the increase, if any, may be apparent rather than real, and due to greater statistical accuracy now than formerly. Granting better kept records, there is yet too marked an agreement in the general testimony obtainable, to allow of reasonable doubt in the matter. There is more reason to suspect an under than an over estimation of the actual number of cases. The concealment whenever possible of suicide as the cause of death, is a natural and excusable desire on the part of relatives



of the deceased; and, again, it is often difficult to pronounce with certainty whether death, as by drowning, firearms, poison, falling from a height, being run over, etc., was intentional or accidental. The benefit of what is frequently no real doubt, is yet often charitably given the victims of circumstances.

Again, a very large number of cases of attempted suicide, which every one may note for himself in the daily press, gain no official recognition whatever, although both from a sociological and pathological viewpoint they ought to be recorded and investigated.

The average reliability of the statistics referred to can hardly, however, be called in question to any great extent, unless, as has been said, to contend they are too conservative. Brierre de Boismont, in his work "Du Suicide," expresses the opinion that in Paris, at least, the registered number of suicides might be taken as representing about half of those actually committed. And Strahan, member of the Medico-Psychological Association of Great Britain and Ireland, in his admirable study of "Suicide and Insanity," commenting on the above statement, points out that in England and Wales the number of verdicts "Found Dead," and "Cause of Death Unknown," as the result of inquests, more than equal the number of cases recorded as "Suicide." The figures for England and Wales, moreover, show a steadily progressing annual increase of deaths by choice. In 1867 the ratio was 61 to each million of population, in 1895 it was 92 per million.

No attempt will be made to give statistics for every Continental country, but it may be of interest to quote the Berlin correspondent of the *Journal of the American Medical Association* under date of November 10th, 1910, who says in part: "According to statements made by Dr. Schilling, the frequency of suicide in Europe has increased since 1831 by 400 per cent., while the growth of the population is only 60 per cent. . . . Only in a few countries, such as Norway, Denmark and Spain, has the number of suicides decreased. In addition there is no doubt that, as a rule, the number of suicides is materially larger than the official figures, as cases of suicides are frequently concealed."

The prevalence of suicide in the German Empire is especially noticeable. It has been characterized as "A Mania for Suicide." One recent result of this mania is almost pathetic as well as amusing, namely, the issuing at Berlin, in January,

1910, by the Association of Hotel Owners, of a public appeal addressed to persons contemplating suicide, urging them to refrain from carrying out their designs while enjoying the hospitality of hotels and lodging houses, because of the annoyance and expense caused proprietors, and naively pointing out the large number of places available for their taking-off without inconvenience to anyone.

France, also, has a high suicide rate, and Doctor Hoisholt, of Stockton, California, in the *California State Journal of Medicine*, February, 1909, states that those departments where the most alcoholic beverages are used, show the highest record of suicide, insanity, and crime. It should be added, however, that the consumption of alcohol, generally speaking, is said to be diminishing in France, although statistics within the last two years, show an increase in the amount of absinthe consumed, one of the most deleterious of drinks in its effects upon the nervous system.

Apropos of suicide and the consumption of alcohol, there may or may not be any direct connection between the prevalence of self-destruction in Germany, and the statement in the Berlin *Reichsarbeitsblatt*, in April, 1910, that the average annual per capita consumption of pure spirit alcohol was 6.79 pints, and of beer, 205.32 pints. On the basis of previous estimates, the additional figures for wine would be 10.24 pints per capita.

But it is the increase or decrease of suicide in the United States that chiefly interests us in connection with the evolution of this class. We have the figures of the Census Bureau for the registration area for 1908, the number being 8,332, and for 1909, 8,402, the latter being less than the relative increase of the estimated population for that area.

On the other hand, one authority reported the average rate of suicide in each 100,000 of population of sixty-five American cities totaling 17,000,000 inhabitants, as 16.8 for the five years, 1894 to 1898 inclusive; 17.5 for 1899 to 1903 inclusive, and 19.5 for 1904 to 1908 inclusive, the rate for 1908 being claimed as the highest ever reached in this country.

It is interesting to note that, geographically speaking, this increase was found to be greater in the Southern and Western States, that is, in the rapidly growing newer centers, where only partial adaptation to the stress of city life can have taken place. It is pertinent to the subject to inquire to what extent

we may expect to find that normal elasticity of mind and body which will automatically, as it were, successfully bring about this essential readjustment.

Madam de Stael, in her essay "Reflections on Suicide," says: "The tissue of our lives is almost entirely composed of the continued action and reaction of internal strength against external circumstances, and of external circumstances against internal strength." But how about internal and inherent weakness?

It does not take a scientist to enunciate the truths set forth by Charlotte Bronte, in "The Professor" that, "A man of regular life and rational mind never despairs," nor did it take a scientist to originate the popular saying: "Every man has a screw loose." It does not take an expert to decide that the man who leads a "Regular Life" is becoming something of a *rara avis*. An irregular life is not necessarily, either, a life of dissipation as commonly interpreted, but often only a life of the daily dissipation or excessive dispersal of nervous energy in the channels of industry, in the keen competitions of trade, the ticking off of the tape, the concentration of the pursuit of knowledge or of social advancement, or even in striving to make both ends meet in these anxious days of soaring prices and salaries lagging far behind.

There are the corporations and the trades unions both working behind strong fortifications; but there is the great public, between the upper and the nether millstone, unorganized and unprotected and subjected to the full force of the strain of fluctuating and unfavorable environmental conditions.

When to the above is added the extravagant and boundless ambition of the day, to eat more, drink more, know more, spend more, acquire more, dress better, ride faster, fly farther, exercise sexual powers to the utmost, and repudiate all escapable obedience to the laws of moderation and self-control, then is it any wonder that flesh and blood is poverty stricken in the matter of sound constitution and normal mental functioning, and bids fair to be absolutely bankrupt and lunatic long before this terrestrial sphere becomes uninhabitable?

It is asserted, and apparently with reason, not only that psychic causes rather than physical suffering, are responsible for the largest number of self-destructionists, but also that the increase in suicidal frequency affects the well-to-do, prosperous



and better educated elements of the population, more than the unfortunate, the ignorant, and the poor.

When this paper was first commenced, I had some curiosity to note the social status, cause, and method of suicide, so far as known, of the first fifty cases coming to my attention. These included a publisher, missionary, two students, an artist, author, millionaire, ex-millionaire, physician, boy speculator, contractor, fruit grower, mill-hand, moulder's helper, clerk, magistrate, secretary, six women at home, a stock broker, superintendent of a railway division, ex-chief of a fire department (a blacksmith), two machinists, two steamship passengers, a boy of nineteen, a school boy of fifteen, and "out of work," a teamster, discharged insane hospital patient, a business man, an old man of seventy, a laborer, farmer, vice-president of a shoe manufacturing concern, the status of the remaining men and two women not being given.

Sixteen of the fifty died by shooting, seven by hanging, seven by poison, four cut the throat and one the abdomen, six died by drowning, five by gas, two by jumping from a great height, one leaped into white hot metal in a foundry, one not stated.

The causes were noticeable because, even in so small a number proving representative of those we might expect: Melancholia following surgical operation, one; melancholia from ill health, nine; "nervous prostration," two; grief, three; overwork, three; overstudy, one; worry over lessons, one; worry over stocks, one; worry over accidents to employes, one; intoxicated, one; fear of being run over by autos after being once hit, one; fear of not meeting husband on arrival in the United States, one; fear of going blind, one; domestic difficulties, one; disappointment in love, two; disappointment at not receiving an expected gift, one; out of work, one; "temporary despondency," one; suicidal mania, one; acute mania (homicide followed by suicide), two; beaten in a horse trade, one; desired "a more moral world," one; taunted for being idle, one; "tired of the United States," one; married three weeks (followed the example of the first wife who suicided), one; "nothing to be thankful for" (a Thanksgiving suicide), one; "wanted a vacation," one.

Of the remainder, cause not given, one jumped into the ocean from the deck of a liner, one leaped into white hot metal in a foundry, one jumped down a smoke-stack a hundred feet. The last two were very probably of the irresistible suicidal im-

pulse type. The wording of the causes as stated by the press reports has been followed: Often the authority is the suicide himself. The comparative triviality of many of the reasons, illustrates excellently well the point so deserving of emphasis in any consideration of suicide as it obtains to-day, namely, the lack of poise, of equilibrium, of normal reaction to the stresses of life, to even the more ordinary demands upon the individual.

This nervous instability is not confined to adults. Child suicides are on the increase. Professor Eulenberg, the prominent neurologist of Berlin, states that between 1880 and 1903, 1,152 children took their lives in Prussia, and that in about 10 per cent. of the cases no cause could be found, in many others only trivial causes, such as the refusal of parents to allow certain games or recreations. Dr. Creidenberg's studies in Russia, show that in one year 436 children in the Government schools killed themselves. He says: "Amongst the boys inherited maladies and erotic reasons take the first place; among the girls trouble with teachers or parents." According to the United States Census of 1900, there were 275 suicides less than twenty years of age.

There is neither a sufficiently careful study made of these cases, nor, as a rule, sufficiently accurate data obtainable. Eulenberg, who selected 284 cases of child suicide for special study, cases concerning which he could get reliable information, found that 29 were markedly insane, fifty-one had exhibited a "feebleness of mental constitution," 135 were either peculiarly unfitted for school life or suffering from special defects of character and temperament.

That there is often, more often than we realize, a hereditary basis for this nervous instability can not be doubted. This fact is brought out in my paper on "Heredity and Environment with Special Reference to Mental and Nervous Diseases." Those transmitting an ancestral taint of chronic diseases or defective mentality can not expect sound offspring. But more than this, a radical departure must be made from present methods in the up-bringing of youth.

Dr. Henry Morselli, professor of psychological medicine in the University of Turin, to whom we are indebted for perhaps the most noted and most exhaustive treatise on suicide, although published many years ago, said even then: "The education which is now given to children assists a premature development in the new generation of the reflective faculties, and

of the passions; hence we need not be astonished if, in the towns especially, the suicides of young men and young women hardly on the threshold of puberty are constantly multiplying."

The excessive stimulation of children's and young people's mental powers and emotions is productive of serious harm to the nervous system, while even more dangerous is the too often total lack of effect of education and self-control, obedience to authority, respect for the rights of others and of society in the aggregate. Children are brought up not to resist but to succumb to the social diseases of extravagance, pleasure, greed, and to crave the excitement produced by drugs or alcohol and indulgence in sexual passion. They are trained for this ultimate wrecking of character and mind by not being trained in the qualities making for strength and stability.

Recommendations as to the preventative treatment of the possible or probable suicide may be deduced in part from the foregoing. It should also be pointed out as a hopeful sign of the times, that there are fortunately more prophylactic resources available to-day than ever before. They are not sufficiently remembered or resorted to, or we would not find under restraint and constant supervision, or sadly needing such, so many discouraging cases. Among the large class designated broadly as degenerates, those with suicidal impulses are not infrequent, while the manic depressive group of melancholiacs require the most careful and vigilant watching, since their persistence and ingenuity encompassing self-destruction are often marvelous. "Although suicide is most common among melancholiacs," says one writer, "patients with general paresis, paranoia, epileptic psychoses, and toxic delirium sometimes attempted." These are, to a large extent, the hopeless cases.

But it is the suicide embryo, as it were, that has the most vital interest for us, the man or woman on whose path the shadow of coming events falls though ever so lightly. There is yet time; the means are ample; an abrupt halt can often be called in the manner of life that favors the development of threatening tendencies. The man himself or the woman herself knows that some radical change is necessary. Wandering up and down the face of the earth may be the thing, or new environment with relaxation of nerve tension in the safe shelter of some cheerful and home-like sanitarium, either with pleasant people and enjoyable diversions, or, if necessary, in quiet, rest and seclusion while the up-building of mind and body



through hygienic and medicinal aids goes on under the unobtrusive direction of the physician.

Recuperation, freedom from worry, fear, ill-considered impulses, over-taxing of the delicate mechanism of brain and nerve, correction of bodily ailments and ill-regulated living—let the sufferer with dark and despairing thoughts seek these means of release in favorable surroundings, and, ninety-nine times out of a hundred, he will not seek them in vain.

Meanwhile society can do a great deal for itself to lessen the suicide class: it can deprecate pessimism and encourage optimism; welcome and co-operate with the safe, sane man and his safe, sane plans of betterment; make the newspaper cultivate brevity or abstinence in the mentioning of crime and suicide, the purveyors of alcohol sell pure beverages only, the tempters to illicit sexual indulgence at least ply their trade among an informed and instructed youth, the illegal venders of cocaine and other drugs look at life from behind prison bars.

Society can do a great deal for itself; it can above all else set up a better standard of what is worth while than obtains today, with the result that the individual—the individual who collectively is society—will more often escape the walls of an asylum or a suicide's grave, and more frequently leave to his children that for which money is no equivalent—a well-balanced mind, and a healthy nervous system.

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#### DIVERTICULITIS OF THE CAECUM NECESSITATING OPERATION.

BY

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(Read before the Homœopathic Society of the State of New York, Buffalo, N. Y.,  
October 8th, 1912.)

BECAUSE of its unusual features, the following case of diverticulitis of the caecum is considered of more than ordinary interest, and worth reporting:

Eighteen years ago I operated on the patient for an acute recurrent attack of appendicitis. I quote from my "operations" notebook: "Appendix three inches long, obtusely angulated with the caecum, and buried in mass of exudate. Removed with unusual difficulty. Distal end contained small

abscess. Defective drainage and subsequent infection probably due to acute flexion of appendix. Very short meso-appendix. Iodoform gauze drainage of the abdomen." To-day I would probably have closed the wound.

He made a satisfactory convalescence and remained well and free from consciousness of his right side until about one year ago, meanwhile enjoying a rather strenuous amateur athletic life in the country.

Without definite cause he gradually began to suffer more or less discomfort in the caecal region, at times reaching a severe colic, with pyrexia, temperature frequently reaching 103, attended with abdominal distention, nausea and extreme tenderness over the entire right side. The attack would subside and at first left no evidences of the local trouble. Distance from town prevented me from seeing the gentleman during one of these attacks, but his medical attendant tells me that in every respect they presented the classical picture of an acute appendicitis.

During one of the intervals, which were becoming shorter, he came to my office for examination. I found an extremely sensitive body in the region of the appendix, and an enlarged caecum, with considerable local exudate, which I without hesitation in view of the clinical history, diagnosed infection at the site of the former operation—the pedicle was tied with silk after the fashion of those days—and advised an immediate operation. I expected to find an abscess, Lane's kinks, membranous bands, and no end of things, the result of some fault of mine, knowing that such results will sooner or later confront the surgeon himself, or possibly through some other operator who finds him out.

I made a liberal incision through the rectus muscle the better to reach the infected area, and free the caecum from adhesions and reach the kinked(?) ileum. To my surprise the region of the former operation was entirely satisfactory. No evidences of removal of the appendix could be found, even the ligature had become absorbed. Neither were there the adhesions and cicatricial tissue that so frequently remain after drainage. Surgically the case was perfect. But further search found the body that I had felt lying outside of the caecum, covered with peritoneum—retro-caecal. It apparently originated from the caput coli in the region of the former appendix, but was turned outward and upward, not in the direction of the

normal appendix, but in the position in which that organ is sometimes found.

The operation presented no other difficulties than usually attend a retro-caecal appendix. The process was two and one-half inches long, possessed no mesentery, and upon section showed a lumen communicating with the intestine. It contained several fecal concretions. There was little evidence of inflammation, though there were two strictures sufficiently well developed to favor absorption—hence the pyrexia—and to cause the attacks of pain, appendicular colic, from which the patient had been suffering.

The retro-caecal situation of this body, and the consequent necessity of shelling it out of the peritoneum offered an opportunity to reduce the size of the caecum by turning its walls in, with sewing together the incised peritoneum, a procedure I always follow when there is dilatation and enlargement of the caecum.

Recovery was rapid, and the patient remains entirely free from attacks of what, for clinical purposes may be called appendicitis,—from a second appendix.

Now what pathological condition was present in this case to give rise to such definite symptoms of appendicitis when no appendix was present, and how can the length of time that elapsed between the first appendectomy and the necessity for the second operation, be explained? Anatomically we have to deal with a very much enlarged, and unusually well developed diverticulum of the caecum, that was present at the time of the primary operation, but being small and buried under the peritoneum gave no sign of its presence. Later a fecal concretion became impacted in its lumen, with the classic symptoms of appendicitis following.

Such a diverticulum appears on the inner side of the caecum between the seventh and eighth weeks of embryonic life. This body does not usually increase in size with the caecum, but for a time remains stationary, gradually disappearing as the true appendix, which becomes a distinct organ between the sixth and seventh month, is differentiated from the caecum.

Embryology regards the appendix, which is a distinctly marked organ only in mammals, as a lymphoid diverticulum from the caecum; the present case establishes the fact that diverticula containing lymphoid structures may not be tran-



sient organs, but may remain and present a clinical history of true appendicitis.

Diverticula of the large intestine are not rare, but they have been observed much more frequently in the sigmoid than in other divisions of the colon. Some years ago I operated on such a case in a young girl. The clinical picture was one of acute suppurating appendicitis save that the pathological focus was on the left side. When I saw the case and took it for operation there was general peritonitis, with septic intoxication. I removed an organ similar to an appendix, without a mesentery, from the sigmoid. It was gangrenous and sloughing, in which process a considerable portion of the omentum had become involved. The abdomen contained a great deal of free pus, and the operation presented all the appalling features and technical difficulties that could be encountered in the gravest appendectomy. My notes say, "Almost insuperable difficulties in separating adhesions, securing pedicle, and cleansing the abdomen." She passed through a most satisfactory convalescence for a drained case.

Diverticula of the large intestine usually disappear before adult life. They are also generally multiple and rarely attain a greater size than buds developed under the peritoneum; slight elevations on the intestinal wall. The present case, and that to which I have referred are evidences of the serious conditions that may develop when they persist, and become permanent structures.

Transient, or temporary organs must in the economy of nature be regarded as serving some purpose, but continuance beyond the period of their usefulness indicates an absence of harmonious development, and a disturbance of the mutual relations of parts that must under favorable extraneous conditions make for disease. It is a general law that knows but few exceptions, that vestigial organs are especially liable to disease, and prone to take on those metabolic changes that lead to vicious nutrition. In the present case the caecal diverticulum possessed lymphoid structures, and its lumen remained patent, two features that perverted its normal transient life, and fitted it to assume the role of a permanent organ.

The combination of conditions that interfere with drainage of the appendix, which is the sum of those that precede appendicitis, were the same as those that caused inflammation of the caecal diverticulum in the case here reported. The pathology

and clinical course of the two conditions were identical. Given a tube containing lymphoid structures, communicating with the caecum, whether it is normal or vestigial, that remains over the period for its disappearance, like causes will produce like results. For all purposes, clinical or surgical, this diverticulum was an appendix, when inflamed it caused similar symptoms, and required similar treatment.

Why after eighteen years a fecal concretion should have lodged in its distal end, or why it should have developed sufficiently for such lodgement, I cannot say, any more than can be said of the conditions that lead up to many cases of true appendicitis. Like other questions in medicine we can only continue seeking for an explanation, and like other conditions calling for surgical interference we must frequently operate for what exists, adapting our technique to what we find, with possibly no very clear conception of the cause, or the pathology, the motive of our work being to remove any anatomical abnormality, and restore by mechanical means the function of the organs or parts.

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### **POLIOMYELITIS.**

BY

**BURT J. MAYCOCK, M. D., BUFFALO, N. Y.**

(Read before the New York State Homœopathic Medical Society.)

INASMUCH as there have occurred, not only in Buffalo but in various parts of the country within the past year, numerous cases of poliomyelitis, it would seem opportune for us to give it more than a passing notice at this time. In Buffalo we have had, since January 1st, 275 cases with 33 deaths. Of the cases that lived 50 per cent. are left permanently paralyzed in some portion of the body.

The disease has prevailed more or less in all parts of the country, from Maine to California and from Alaska to Florida. It has been particularly severe in Los Angeles, Cal. One of the worst epidemics of the year occurred on an island directly under the equator, while in some sections of Alaska last winter it was also very prevalent. So it would appear that temperature had but little effect upon the disease. Statistics show us, however, that in this section it is more prevalent during the summer months, that is from July 1st to November 1st.

The disease seems to be no respecter of persons in that it affects the rich and the poor with equal impartiality. One of the peculiar features about it is, that while we recognize it as an infectious disease, it has been very uncommon to find more than one case in the same household. It seems to spread, in most instances, by jumping from one section of the community to another and in most cases it has been impossible to trace the source of the disease.

Although infectious, it is not nearly as much so as most diseases of this class. We know that practically everybody is susceptible to measles and will take the disease at some time during their life if exposed; that to a less extent everybody is susceptible to small-pox and other germ diseases. But in poliomyelitis this susceptibility is not nearly so marked. Of a very large number exposed but very few will contract the disease. We are frequently asked now-a-days about this "new disease." It is not new by any means. Evidence of it has been found in an Egyptian mummy dating back 3700 B. C. In 1840 Von Heine gave a fairly clear description of it. It has occurred in the sporadic type in this country for the last seventy-five or eighty years, and has been more or less epidemic for the last ten years. In 1894, 136 cases were reported in Vermont; in 1905, in Norway and Sweden there were about 1,500 cases. In 1907, in New York City and vicinity there were about 2,500 cases, from 1907 to the present time more or less severe epidemics have been reported in almost every State in the Union. The New York State Department of Health takes particular pains to call the attention of the medical profession to the fact that the disease is not confined to infants, but may also affect adults. Hence the term "Infantile Paralysis" is a misnomer and misleading. In my own private practice this year, out of five cases two have been in young adults, one aged nineteen, the other twenty-five. The large majority of cases occur, however, in children under five years of age. The greatest number in the first two years of life. Poverty and unsanitary conditions, as suggested above, seem to play no part in the spread of the disease.

The particular organism which causes poliomyelitis has as yet not been isolated. It is evidently ultra-microscopic, for it passes undisturbed through the finest porcelain filters. Emulsions made from the spinal cord of those who have died of the disease, passed several times through a Berkfeldt filter will in-



variably produce the disease when injected into the brain or spinal cord of monkeys. And, by the way, the monkey seems to be the only one of the lower animals that is susceptible to the disease. Cases of paralysis amongst other animals, horses, cows, chickens, etc., which are reported during an epidemic of poliomyelitis, like "the flowers that bloom in the spring have nothing to do with the case." Investigation has proven that the cases are not poliomyelitis and are not more common during this epidemic than at other times—they simply attract more attention. Almost invariably inoculation into the spinal cord or brain of monkeys will reproduce the disease in from five to forty-six days. Usually it is possible to reproduce it by rubbing the poison into the mucus membrane of the nose, especially if the membrane has been scarified. In rare cases the disease has been transmitted through the gastro-intestinal tract by feeding. It seems to be a fairly well established fact that the port of entry is through the mucus membrane of the nose and throat and that the poison that is discharged by those affected is carried by the mucus secretions of those organs.

The beginning of the disease resembles that of most infectious diseases; we have fever, more or less aching all over the body, not so marked as in grippe; gastro-intestinal disturbance, headache, particularly in the back of the head and usually a pain and tenderness down the spine. There is a strong tendency on the part of the child to sneeze and with this is a marked irritation of the throat; so decided is this symptom that mothers not infrequently think the child is coming down with the measles. Upon inspection, however, we find that the nose and throat are not congested or hyperæmic, but are pale, somewhat œdematous and covered with a glairy, frothy mucous. This symptom is said to be pathognomonic. It is to be remembered that we are dealing with essentially a meningitis and the symptoms will be those of that disease. Within twelve to forty-eight hours the pain will be fairly well located in some portion of the body and paralysis of the part will rapidly ensue. It has been characteristic of the present epidemic in Buffalo for the paralysis to affect only certain groups of muscles and not an entire extremity. I have with me charts of cases which I have seen at the Earnest Wende Hospital for Contagious Diseases, showing the muscles or groups of muscles which have been affected. We must remember that old definition of inflammation, "tumor, dolor et calor" still holds good. The "calor" and the "dolor"

speak for themselves; the "tumor" is the swelling which causes the paralysis of the part supplied by that section of the cord. The higher in the cord the inflammation the more serious the case, because it affects more vital organs. If the swelling of nerve cells is merely a congestion of oedematous condition, the paralysis will clear up. If, however, the process goes on to the destruction of the cells then the paralysis is permanent.

As far as prevention is concerned it is obvious from what we have said that disinfection of the nose and throat is of prime importance. Personally, I have my patients, especially those at the susceptible age, spray twice daily with boracic solution. The giving of urotropin and formin seems to me too empirical and too theoretical; it is based merely upon the fact that these substances are antiseptic and that after administration by mouth, formaline has been recovered from the spinal fluid. I suppose it is well to keep children by themselves, but considering the way the disease jumps and the infrequency with which we can trace one case from another, I doubt the efficacy of this method of prevention.

The exact period of infectivity has not been determined, but it is known that during the febrile period, which usually continues for about three weeks, patients suffering from poliomyelitis are capable of transmitting the disease to others; therefore, during the febrile stage all patients should be isolated.

It is probable that the infectious agent is carried not only by those who are or have been ill but also by healthy people who have come in contact with the disease. The State Department and our local Board of Health advise the isolation of all patients as soon as possible after the appearance of the first symptoms, not waiting for the paralysis to appear. No one other than the physician and the attendant should be allowed to enter the sick room, and these should not mingle with other people until after a thorough disinfection, such as is done in other contagious diseases, with the additional precaution of disinfecting the mucus membrane of the nasal passages and the throat. All secretions of the mouth and nose of the patient should be destroyed, preferably by fire or by bichloride or carbolic acid solution. The bedding, clothing or other material that may have been infected should be thoroughly disinfected before leaving the patient's room. In fact, every precaution which we are accustomed to take in the other communicable diseases should be followed here.

As far as treatment is concerned, according to the so-called authorities on the subject, it is like the snakes in Ireland—there isn't any. The treatment which is followed by the old school is rest, urotropin and, if there is much pain, aspirin. When we remember that we are treating practically a meningitis, we know that we homœopaths have a great advantage. What if we do know the exact organism which causes the trouble? That seems to me of minor importance; we do not know what causes small-pox, measles or scarlet fever. We are not treating some particular germ, but we are treating a particular patient. The remedies to be used are probably better known to most of you here than they are to me. *Gelsemium* seems to be frequently indicated. In the early stages *aconite*, *belladonna*, *bryonia*, *arnica* and remedies of that class are useful. After fever and irritation of nerve cells has subsided gentle massage and the faradic current to the affected muscles and high frequency electricity appear to help. I would very much like to know the results of homœopathic treatment in this disease if figures can be obtained.

While I believe it is wise to take every precaution against the spread of the disease, still I believe that there is a lot of unnecessary hysteria concerning it. To my mind, the scare is being stirred up in this city by a few so-called specialists in diseases of children.

I may be called a medical renegade, but in spite of that I do not believe in getting alarmed over an alleged epidemic in which we have one case to 2,000 population. The idea of keeping schools closed and children out of town, when, as we know, the disease is also prevalent in country districts, seems to me absurd.

It is not altogether the number of deaths or the number of cases to the population that frightens our patients, but it is the paralysis that paralyzes the mothers.

Please do not misunderstand my attitude on this subject. I believe in doing everything to stamp out poliomyelitis, but I do not believe in getting excited over it. In Buffalo, since January 1st, we have had 278 cases with 33 deaths. Up to September 1st, we have had in the city 2,781 cases of measles reported with 46 deaths. We have had 435 deaths from tuberculosis, with 2,000 to 3,000 cases in the city. I fail to hear of people getting especially nervous over measles or tuberculosis. In New York State, from January 1st to September 1st, there have



been 568 cases of poliomyelitis with 86 deaths; 56,966 cases of measles with 930 deaths; of tuberculosis there have been reported 21,002 cases with 9,617 deaths, still it seems impossible to get proper accommodations for the care of chronic cases of tuberculosis. During the present epidemic we have had in this city the services of Dr. Frost, representative of the Marine Hospital Service; Dr. Fraser, of the Rockefeller Institute in New York, and Dr. Hills Cole, representative of the New York State Health Department. Houses in which the disease occurs are placarded, but no strict quarantine exists. Cases that cannot be properly cared for at home are sent to the Earnest Wende Hospital, where two wards are set aside for the special care of these cases. In case of death the funeral is private as in other contagious diseases.

In addition to this there has been a nurse appointed who is especially qualified along these lines, to visit the houses of the poor after the infective period has passed, to give massage to the patient and general advise to the family for the care of the child. Two well-known orthopedic surgeons have been designated by the Health Department, who will, on request, visit any poor family and give advise on the after-care. None of these see cases during the infective period.

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### MUNICIPAL CONTROL OF VENEREAL DISEASES.

BY

A. W. BELTING, M. D., TRENTON, N. J.

Recent Surgeon to the Genito-Urinary Department Wm. McKinley Hospital.

(Read before the Mercer County Homœopathic Medical Society, at Trenton, N. J., October 16, 1912.)

My excuse for offering this paper is prompted only by my sincere belief in the immediate necessity of municipal control of venerealism and not in any sense by my ability to cope with the subject as it deserves. How many times we hear the statement that this is a progressive age which statement is borne out in the very many evidences of time saving devices, labor saving machines and the many means employed to obtain a desired result in the shortest possible time and along with these, scientists are ever introducing to us some new discovery that brings to the possible what has before seemed to be impossible, nor

has the science of medicine in its allied branches been standing idly by, for we have been favored by such aggressive men as Jenner, Pasteur, Koch, and, perhaps, last but not least, Ehrlich, who have brought us fairly up to the line of modernism and progressiveness. So we are brought up not only to the realization of the actual cause of disease and its best and therefore most effective means of combat, but one step further, namely, to the prevention of disease and so we aptly term this the preventive age, as applied to medical science.

There are two well recognized means of preventing disease. First, by increasing the resistance of the body. Second, by immunizing the body. There are also at least two prime factors that tend not only to control an existing disease, but to entirely eradicate it.

First, absolute isolation of the patient.

Second, successful quarantine and immunization of those exposed. This leads to the subject matter of this paper.

#### THE MUNICIPAL CONTROL OF VENEREAL DISEASES.

There is no dispute in the fact that generally speaking, venerealism is one of the greatest, if not the greatest disease that is menacing human life to-day and it would seem to the writer that he is not far wrong in saying that in proportion to the ravages it makes upon its victims, its responsibilities for so great a percentage of permanent invalidism and insanity, together with its terrible rate of mortality, that it has not heretofore had the prominence among medical scientists and public health organizations as it deserves.

According to Sir Alfred Keogh, an associated author of a "Manual of Venereal Diseases," syphilis was recognized as far back as 1494, so that it is not a recently discovered disease, but since that time what has been done to eradicate it from our midst? It would appear that the only organized effort to treat venerealism has been in the army and navy, under the control of the various governments, whose efforts have been crowned with considerable success. This result has only been obtained by reason of legislation; citing the British Cantonment Act of 1897 over its army of India. The main features of this act are as follows:

A. Establishment of Cantonment general hospitals for the reception of cases of contagious diseases as well as other diseases.

B. Power to compulsory examine and detain those suspected from such diseases.

C. Power to exclude any persons from Cantonement who do not comply with the provisions of the act.

D. Power to remove brothels and prostitutes.

E. Exclusion of brothels and prostitutes from regimental bazaars.

F. Prohibition of loitering and importuning.

Other causes which have co-operated are probably increased temperance, the personal influence of regimental and other officers, lectures on the advantage of temperance and continence by chaplains, medical officers and regimental officers, the placing of dangerous places out of bounds, the prolonged continuous treating of cases of syphilis out of hospital, encouragement of games, athletics and rational amusements in the barracks, etc.

Now it would seem we have in the foregoing a plan of procedure of the greatest army of the world, a very good example to follow in our endeavor to permanently stamp out venerealism in this country. This procedure comprises these factors, namely:

Educating the public mind to the awful prevalence and more awful results of venerealism amongst us. With education follows legislation and you can accomplish nothing without suitable laws, not alone to force submission to those afflicted but to as well protect those innocent. This means that the laws must necessarily vary according to the conditions found in the different communities and cities. As regards our modern city, it would seem to the writer that with the local hospitals in combination with the municipal hospital we should be able adequately to meet this condition provided suitable legislation could be enacted.

Is it not good philosophy to argue that cases of syphilis can be better controlled in themselves and the community at large better protected by having these cases first registered as such in our local health board and then treated in special wards of the local hospitals, committing all charity patients to the municipal hospital until recovery? This thought is prompted from an abstract of an article entitled the attitude of hospital boards to venerealism by Dr. William Thomas Corlett in the *Journal of the American Medical Association*, Oct. 5th, 1912, in which he says, "Most hospitals not only make no provision



for syphilis, but refuse patients who seek admission for this disease. In the city of Cleveland only one hospital receives syphilitics, the City, or Municipal Hospital; at the same time, in all hospitals there is a very high percentage of syphilitics admitted, because the disease is not recognized and because the patients, admitted for other affections, are found to be also syphilitic. This applies to all departments with about equal frequency. Even orderlies and nurses employed by the hospitals have been found to be in the most active stage of the affliction. More danger is encountered in these random, unknown cases than when special wards are provided and proper precautions are observed in their management. Moreover, it demonstrates the utter futility of attempting their complete exclusion. Formerly the need was less urgent for such accommodation than at present. With the treatment of salvarsan it is indispensable to have such patients admitted to the hospital for short periods. Prompt measures at the onset will prevent the dangers that always exist to others, and afford the most favorable opportunity of eradicating the disease from the patients' system. In all hospitals, therefore, a male and female ward should be established for syphilis. In this regard, boards of managements and superintendents should be better informed concerning the gravity of syphilis and the relation which the disease bears to the general community. The mistake has arisen in looking on syphilis as a disease confined to the low and vile, while in reality it is encountered in all grades of the moral and social scale; furthermore, the number of blameless persons afflicted with this affection is remarkably high. If special provision were made there would be far less likelihood of such cases being so scattered promiscuously through the various services of a hospital as now occurs under the rule of exclusion, which is wholly theoretic, for in actual practice it does not exclude. Nor should these cases be excluded."

Is it not the duty of the medical profession to husband this new departure in the form of public control of gonorrhœa and syphilis rather than have it forced upon us by the laity? To quote Dr. Henry P. Walcott, of Boston, chairman of the Massachusetts State Board of Health, "The venereal diseases are over-perplexing subjects for State control. Our various experiments in this direction will be brought to your attention. It is too early to claim results of much value, but hardly any

one disease is of so much importance to the public welfare as this is, and the time is long since past for neglect and silence concerning it."

It is the opinion of the writer that all cases of venerealism should be promptly reported to the local health authorities, whose duty it should be to at once furnish to the patient afflicted, rules to be observed in the government of his or her case if allowed to remain at home; that is, suitable isolation or, in severe cases, even quarantine of the case, and I would say that absolute isolation should be observed in all cases of syphilis in the nearest private or public hospital, according to the financial ability of the case until pronounced cured by the attending physician.

The promiscuous mingling of syphilitics among the community is certainly a public menace to the non-infected.

It has occurred in three instances in the private practice of the writer to have treated syphilitics who were employed in public restaurants as cooks and waiters, which serves to evidence the need of suitable legislation for the municipal control of this dread disease.

To summarize: With venerealism included in the clause under the act of restrictive diseases affecting immigration we at once shut out from our country one great source of the spread of this disease, then with suitable State Board of Health control over the several local health boards of the different municipalities, as is given for the protection of the healthy public, and the control of those afflicted with contagious disease, we are approaching at least the ultimate control and even the eradication of this disease so aptly called The Great Black Plague.

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A SIMPLE MEANS OF REMOVING PLASTER APPARATUS.—In spite of the use of special instruments, the removal of apparatus containing plaster-of-paris is often troublesome, and in the case of a recent fracture may cause injury. Methods of softening the plaster by water, either alone or with the addition of salt, are rarely successful, as the apparatus becomes coated with a layer of grease which prevents their action. The writer has obtained satisfactory results by moistening the line of section with vinegar applied on a tampon of wool. After a minute the plaster will be found completely softened so that it may be easily divided with a pocket knife or ordinary scissors—a procedure easy for the surgeon and painless for the patient. By this method a plaster case for a fracture of the femur, consisting of 80 turns of bandage, may be removed in about a minute and a half.—*Stransky (La Semaine Medicale.)*

## Transactions of the Homoeopathic Medical Society of the State of Pennsylvania

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### BUREAU OF OBSTETRICS

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AUGUSTUS KORNDORFER, JR., M. D., Chairman

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#### A CONSIDERATION OF THE MIDWIFE.

BY

JOHN E. JAMES, JR., M. D., PHILADELPHIA.

DURING the current year, in the various organization meetings, the attention of the medical profession of our country has been directed to the subject I bring before you, with the primary idea of arousing interest and a recognition of the heretofore inefficient administration of this class of attendants upon cases of labor, and with the ultimate aim in view of procuring more adequate, uniform, expansive legislation that will eliminate certain gross evils dependent directly upon the multifarious regulations which have been permitted to exist. Those who have made this a special study, recently, concede the question to be a problem; and a real problem it is when justly considered, the inability to properly solve which, or an indifference to attempt it, stamping the medical powers of present times either as unprogressive or as apathetic in lacking initiative enough to demand and enforce betterment in all humanitarian concerns over which they possess active supervision and control. The midwife, historically, antedates the presence of the physician in the confinement room. The physician, on the other hand, by virtue of his progressiveness in the light of medical education, training and skill, has long since supplanted the improperly disciplined midwife among the educated classes. In our own country the midwife has persisted, however, for the poorer and lower classes, and in the reformation and advancement of the medical graduate has, until recent times, remained stationary and unimproved; even worse, her existence, apparently,



has been ignored, and though uneducated and untrained, her practice has been in no way curtailed or properly regulated.

To overcome the evils accruing from such neglect it is imperative, first of all, to stir the conscience of the medical profession; then must the laity be shown the consequences and gravity of our omissions of the past and join with us in concerted action to secure legal conditions tending to the ideal, conditions that will be in the interest of all women alike, and which will take cognizance to the fullest extent of the paramount obligations associated with every obstetrical case.

It would appear from the published results of the study upon the midwife problem in America made by J. W. Williams (*Journal American Medical Association*, Jan. 6th, 1912,) that there are many obstetricians who consider the average midwife of to-day does less harm than many a general practitioner doing obstetrical work. This belief I concur in. There is no doubt that ignorance makes the average midwife fearful to attempt those superfluous, unjustifiable manipulations indulged in by the physician who, bedecked with a self-assuring sense of omnipotence in all things medical, does not hesitate to interfere to the extent of converting a strictly normal case into one distinctly abnormal; thus leaving in the wake of nefarious practices, a morbidity and a mortality rate inexcusable. I cannot agree, however, with the belief that the midwife can continue to be ignored and left to do as she will with comparative safety until our efforts have succeeded in eradicating these "irresponsible practitioners." It is logical to presume, and experience tells us, that as surely as we have unscrupulous physicians, do we have, in like measure, unscrupulous midwives, not so fearful as their sisters, whose knowledge has been increased to the dangerous degree of allurements to attempt anything and to practise the art of midwifery in violation of all medical standards of to-day. Consequently, to epitomize the evils of present-day midwifery must our efforts be two-fold and simultaneous. The inefficiently trained, and hence "irresponsible" physician is being eliminated by the demands for more thorough academic training and broader, higher medical education of students; medical colleges are being forced to meet these requirements through legal supervision so as to insure that only the thoroughly trained and equipped graduate shall be granted licensure to practice medicine. Similarly, must our endeavors

be directed toward the midwife. The midwife, in being permitted to attend a woman in labor, is placed immediately upon equal footing with the medical graduate, in so far as trust and responsibility go. How absolutely absurd and paradoxical it is for the medical profession to demand, constantly, more and more of students of medicine, to grill so vigorously the graduates in medicine before licensing them, and then, turn about and countenance the presence of the untrained, unskilled attendant in the confinement room, and the granting to her of a license to practise that branch of medicine so vitally important in having two lives instead of one to be constantly guarded and protected. Even as a temporary procedure, it is difficult to justify such jargon.

Without appearing too prejudiced or too dogmatic, let us for the moment look into some phases of the subject. To begin with, conditions relative to the midwife in foreign countries and, by way of comparison, those in this country are interesting. By virtue of priority and habit, in England and on the Continent the midwife is recognized as a fixture or an apparent necessity. Legislation, in consequence, has been enacted to regulate and to supervise her work; no uniformity of law, however, is found in the various countries and provinces. It appears, then, that the midwife is legally recognized as a competent attendant in cases of labor; but likewise legally, by definite regulation and restriction, her field of practice is limited to normal cases. In Dr. S. Josephine Baker's published investigations of foreign conditions (*American Journal of Obstetrics*, Feb., 1912,) it is pointed out that in Germany, Prussia, Netherlands, France, Austria, Italy, England, there are schools for midwives under governmental control, where professional training is given in courses varying in length in the different countries from six months to two years. In these countries instruction is given, under skilled teachers, in elementary anatomy, physiology, bacteriology, in obstetrical examination by bedside and manikin practice, with special reference to pelvimetry and internal examinations; in the conduct of normal labor, the puerperium and care of infant; in asepsis and antisepsis. To the thoroughness of this training in Austria, personal observation of the work of the midwife in the clinics of the General Hospital of Vienna can well attest. For admission to these schools an age limit is required, France having the widest range, from 19 to 35 years; also, evidences of good health, good moral character and some ele-

mentary education. Upon completion of the course, examinations are held, written and oral, by competent boards, and the successful applicants are granted license. In most of these countries this is for a limited period only, from one to three years, re-examination being required for the renewal of such license. In Germany, Austria and England, particularly, supervision of the midwife is demanded and maintained by specially appointed and paid inspectors, a definite number of midwives assigned to each, to whom these midwives must make regular reports and who, in turn, must inspect equipment, cleanliness, habits, etc., of those under them. Any sign of abnormality among cases must be immediately reported to these supervisors, who then give the necessary assistance. No midwife is permitted to perform any interference or any obstetrical operation unless urgency demands and assistance applied for is not forthcoming.

Let us look to the midwife bred and practising upon American soil. With the exception of two States where midwives are forbidden and the law enforced, up until the past year, this country possessed absolutely no legislation, effectual and adequate, governing requirements, fitness, ability of midwives to attend confinement cases. This is clearly shown in the report published by Dr. Baker upon conditions in this country as studied from the answers received to a series of questions sent to all States and most of the larger cities. To quote from a portion of this report, "thirteen States (out of those replying) have laws regulating the practice of midwives, yet only six knew the number of midwives in the State and only one could state the number of births reported by them. Any system of supervision or enforcement of the law could not be determined in any State except as the matter was delegated to the local authorities of cities or towns." The study of the cities or towns shows that a license is granted to a midwife upon a certificate, of a foreign school, upon a physician's certificate record of number of cases attended or, in some few, upon a superficial, inadequate examination. The glaring fact in this country is clearly, legal neglect or legal recognition without restriction, without proper educational and practical training requirements, without supervision in order to keep the midwife up to a certain recognized standard. This much in a general way; to be a little bit more specific:



In New York City in 1910, for example, there were granted 1,344 permits to midwives; these reported 51,996 births, or 40 per cent. of the total in the city (Dr. Baker's statistics). There was no legislation to properly cover such activities on the part of these attendants upon labor cases. We must give full recognition to the advance step inaugurated in this city in 1911, in founding what purports to be the first adequate school for midwives. This school, under municipal control, through the Bureau of Child Hygiene of the Department of Health, is devised to afford practical training to all midwives desiring license; such licensure being granted to those who pass the required examination. Each license must be renewed annually. Supervision of the methods of practice is to be carried out by the Bureau in control.

The State of Pennsylvania has had a law requiring registration of midwives and making it incumbent upon them to make full return of births. There has been no legislation governing the standard of the practice of midwives; this being delegated, it would seem, to local authorities of the cities and towns. In view of the fact that this State law became extinct on January 1st of this year, and that the present Bureau of Medical Education and Licensure has under advisement the formulating of certain rules and regulations, a study of our local conditions is of interest; and perhaps may result in suggestions being given by this, our representative society, which may bring to pass some legislation in this State worthy of exemplification in the others.

The following facts are gleaned from answers received to a series of questions I sent to twenty-two of the larger cities and towns in this State:

*Philadelphia.*—There are about 178 midwives who reported about 24 per cent. of all births. Until the present time, license to practice midwifery was granted upon presentation of a foreign school certificate, a record of a number of cases treated, or upon an inadequate examination. No arrangements for supervision, it being required only that births be reported. During the past year, we are proud to say, Dr. Newmayer, as chief of the local Bureau of Child Hygiene, has assumed control of the midwives, and is demanding increased proficiency and better technique in management of cases. Those midwives found to be inefficient, according to his standards, are

sent to the Philadelphia Hospital for a six weeks' course in instruction before being licensed. Emphasis is given to acquiring the knowledge and use of antisepsis and asepsis. Supervision of personal cleanliness, home conditions, equipment is to be carried out.

*Reading.*—There are 12 midwives, who return 12 per cent. of births in the year. No requirements as to registration.

*Altoona.*—There are 13 midwives. License is granted upon a certificate from a registered physician. Two hundred births reported annually, or about 7 per cent. of the total. No supervision.

*Scranton.*—Twenty midwives. License is granted upon a certificate or physician's recommendation. No supervision. Number of births reported annually represents about 40 per cent. to 50 per cent. of total.

*York, Pa.*—Two midwives. Eighteen births annually, or about 1.7 per cent. of total. No requirements demanded for license. No supervision.

*LANCASTER, Pa.*—Only one midwife registered. No local requirements for license. No supervision.

*Pittsburgh, Pa.*—One hundred and twenty midwives. License granted upon recommendation of three reputable physicians who have knowledge of their work, or upon diploma of some recognized school of midwifery. Most of those registered are from schools of Austria and Italy. No supervision. In 1911, 4,864 births reported, or about one-third of total.

*Johnstown, Pa.*—Eighteen midwives. Registration the only requirement demanded. In 1911, 639 births reported, or about 33 per cent. of total.

*Easton, Pa.*—Reports no midwives registered. Likewise, no knowledge of any requirements to be demanded before license would be granted.

*Franklin, Pa.*—No midwives. No local requirements demanded for license.

*Norristown, Pa.*—Reports several midwives in its township. No definite number given. Local registration required. No method of supervision. They report about 80 births annually, or one-eighth of total.

*Pottstown, Pa.*—No midwives at present. Prior to January 1st, 1912, there were two. Registration is alone demanded. No supervision other than visits by the Health Officer.

The average yearly report would total about 12 births, or three per cent. of the total.

*Bethlehem, Pa.*—No midwives.

*South Bethlehem, Pa.*—Sixty-six midwives. They are required to register only and to report every ten days. They average about 600 births annually, or two-thirds of the total.

The facts, aside from ordinary interest, show an attitude of culpable neglect assumed by the State authorities in the years gone by in relation to the practice of midwifery; they show the absolutely incongruous, diversified, inefficient regulations in force, entailed by delegating the subject to local authorities. And further, our State being but a type of all, with two exceptions, these facts emphasize the appalling difference in this country compared to foreign countries in the way of neglect, gross laxity and legal mismanagement.

There are two questions now apropos:

1. If the midwife is permitted to remain in this State and country, what requirements should be demanded as to proficiency and competency before legal recognition by licensure is given, and how should her work be regulated and supervised?

2. Is there a need and a field for the midwife in this country?

In answer to the first, without doubt we should follow closely the regulations and requirements demanded in Continental Europe, as already noted; at the same time, broadening and enlarging them and making them uniform for the entire country. I believe a higher degree of preliminary education for admission to the schools of midwifery should be enforced, demanding something more than simply the ability to read and write; and thus, perhaps, at the beginning, have to deal with only those applicants to practice midwifery who are of mental calibre sufficient to fully realize the responsibilities assumed in obstetrical work.

The schools should have, at least, a one-year course, preferably two or three years; they should be under efficient control, and the examinations for licensure should be held by competent obstetricians. Each license should be renewed annually, and only upon re-examination, oral and written. The instruction in the schools should be thorough, embracing normal obstetrics, and so much of the pathological portion as to make the midwife alert to the various abnormalities, to the degree of knowing when to secure assistance, and that, before it is too late.



Because even this much means meagre training to practice obstetrics, and consequently the limitation of the midwife to normal cases is imperative, supervision must be devised and enforced. There must be competent supervisors, ready to respond to calls for aid and who must assume responsibility of all cases of abnormalities before, during or after labor. The question of remuneration of these latter, because of their work among the poorer classes, would have to be solved before the system could become operative.

These should be the requirements, in a general way, to be demanded if we are going to legally recognize the midwife as one competent to practice midwifery.

In the consideration of our second query, as to the need and field for the midwife, we must put aside the standards and conditions of years ago and discuss it from the viewpoint of progressive medicine and the accomplishments of modern medical practice and teaching.

In this light, then, let us agree to advance the standing of the midwife so she may attend normal cases according to modern dictates. According to my experience, possibly of others, too, one of the difficult problems in the practice of obstetrics is the prognosticating of the type of labor in individual cases, in determining which case will, in all probability, be normal, and in that one offering some abnormality, what interference will be indicated in the interest of both lives involved; and then, so to conduct the labor in the apparently normal case that it may be spontaneous and uneventful. For the successful attendant this means a thorough study of each case and an intimate knowledge of the obstetrical examination and of the mechanism for each position of every presentation, in addition to all else pertaining to the subject. We find it difficult to teach this to medical students in extended graded courses and with abundant clinical material for practical instruction. What about the midwife, who, even with the advantages of the increased standard of teaching, must be, comparatively but poorly trained and insufficiently skilled; how will she recognize the normal case; how will she diagnose early enough to seek competent assistance, those deviations so apt to occur and which, if neglected, means probable loss of mother, or of child, or of both? What about the emergencies that may arise, unexpectedly, that mean prompt, intelligent action to offset unnecessary

calamity? The fact that there are physicians "doing" obstetrical work, who under similar circumstances would be as incompetent as the midwife, we have admitted, and it does not afford an answer to this point. We should hesitate to add to the already too large number of "irresponsible physicians" this class of attendants bound to be incompetent, and, likewise, irresponsible. On the other hand, we must take cognizance of the fact that modern thought, medical and lay, is demanding more and more each day that the practice of obstetrics shall be a pure specialty; that there shall be obstetricians to practise midwifery. The time is rapidly passing when the physician, blindly, will trust to providence and a little force in labor cases and in the event of difficulty attempt some ignorant interference, or call in some nearby physician for like effort, or possibly appeal to gynecologist or even surgeon to perform some obstetrical operative work. The physician who will practise obstetrics must know his cases, must study his cases, must follow his cases as an obstetrician; and, in the event of abnormality, he must seek the advice and aid of the true obstetrician, otherwise, he has no right to attempt such practice. The same rule must hold good for the midwife.

What of the antiseptic and aseptic conscience of the midwife; of the mortality and morbidity rate in her cases? Recent studies show that only a certain small proportion of midwives employ antiseptics in managing labor. In Dr. Newmayer's study of midwives in Philadelphia, those who do not know the use of antiseptics or who did not have such in their equipment were to be sent to the Philadelphia Hospital for a six weeks' instruction. This is a step in advancement; yet I fear the knowledge gained in such a limited period would be easily forgotten. The fact that the majority of midwives do not use antiseptics and asepsis, and are at work in the worst environments, makes the presumption certain, though statistics are not at hand to prove it, that the mortality and morbidity rates of the average midwife surpass by far those of the average reputable physician. In Berlin (Emmons & Huntingdon, *American Journal Obstetrics*, March, 1912,) Bumm claims the mortality rate is entirely too high. Recognizing the preponderance of cases attended by the midwife, the inference is clear.

I believe, in accord with reports published, there are fewer

cases of ophthalmia neonatorum in the hands of midwives, proportionally, than in the hands of physicians. The reason is obvious. The midwife, generally, leaves the eyes of the new born child alone; whereas the physician is apt to use a wet instead of a dry initial mop of the eyes; and whereas he fails to employ the Crede treatment routinely, or is led by the fanatics to make use of some supposed and newer germicide in place of the freshly prepared solution of silver nitrate.

We are told the midwife is a necessity to-day because the foreign element, in our larger cities and towns, inculcated with native prejudice and preference, demands her attention; and our poorer classes, generally, seek her because of lessened cost. To my mind, such demands serve only to necessitate legislation tending toward abolition. Were there no midwives, these classes, in place of exposing themselves to the chances of childbirth amid dirt and often squallor would be forced into the innumerable institutions in all towns and districts, offering free service under ideal surroundings and competent attendants. The midwife of modern day no longer enters a home to attend both confinement and household duties. Here, again, is another reason why her presence among the poor is no longer needed. Let the women of these classes go to our institutions, and let our social service and visiting nurse organizations, rapidly spreading to all centres, look after the homes until the mothers, upon their discharge, return from hospitals in a physical condition never to be obtained in their own environments, ready and able to assume their usual duties. To accomplish this we need to educate these lower classes, to be sure; the social service workers and Bureaus for Child Hygiene can do much in propagating such education.

For those women, for whom it is impossible to go to an institution, let us not forget the services of district physician and visiting nurse, and, in medical centres, the value of services rendered by fourth-year students at work under the supervision of hospital staffs, and, again, aided by visiting nurse organizations.

It is of value to inquire as to the effectiveness of the system of regulation and higher standards of midwives in vogue in foreign countries, and, from results there obtained, deduce what we, in this country, may expect under similar legislation and regime. To quote directly from a portion of the report of



Emmons and Huntingdon (*Amer. Journal Obstetrics*, March, 1912,) in speaking of the system in Germany,—“there is the other great defect in the system that, unlike any other branch of medicine, there are two standards of excellence offered to the public. Thus, we see instead of perfect harmony, a waste of precious minutes because of greed and ignorance; divided responsibility because of the nature of the system and also because of jealousy; and two standards of skill where science and logic demand but one. And so, even on the Continent where ages have given the midwife an established position, yet the leading obstetricians will tell you that the midwife has not made good.”

Can we institute similar regulations and legislations and expect something more of the American midwife? Will she be free of all the greed and jealousy which prevent the calling in of necessary aid, and which she knows would be in the interest of her case; will she be more conscientious and competent than her foreign sisters; will her work and results obtained be in keeping with the ideals and standards of progressive medicine? Shall we experiment to determine these points, or shall we recognize and profit by the lessons of other countries? This we agree to, namely, the midwife unregulated, untrained, uneducated, scientifically, is a menace; regulated, trained, educated to the degree generally considered sufficient for her to practise midwifery creates for us a dual system, or two grades of practitioners of midwifery, one superior, one inferior, from which the laity may choose. The latter is an improvement over the former and present-day regime, yet it is hardly in keeping with our modern trend for the betterment in all things, for the abolition of all things detrimental to human welfare. It has been suggested that the time is not ripe for the abolition of the midwife, and to attempt this now would militate against the ultimate accomplishment of such an end; and that consequently we had best content ourselves with the good obtained from demanding higher standards for the midwife; and though not ideal by far, yet permit it as a lesser evil until the time is come to dissolve it.

This, in a measure, sounds logical; yet I believe argumentation tending towards procrastination designates an admission of fear or weakness to act boldly and justly. The time is at hand now, with the agitation present upon this topic through-

out the medical profession of this country, for proper efficient legislation. Supposing we, legally, substitute this lesser evil as a stepping stone to greater achievements later, as a temporary measure only, what may we expect? Simply this, that in our satisfaction of having done something, we will forget, ignore, neglect the incompleteness of our work and very quickly this temporary measure will tacitly come to assume the role of more or less permanency; a permanency of such proportion and legislative precedence that to combat it or overthrow it later will be a difficult task. This is what has happened in foreign countries, with dissatisfaction as the result, of course. Are the conditions of our country of such a nature that we must do likewise, or cannot we be a little more progressive and at once, in full and adequate legislation, eradicate all tendency towards formulating a similar, inexpedient dual system?

Personally, I can see only harm to all our people, without distinction of class, nationality, creed, in legally authorizing two types of practitioners of midwifery. The fundamental importance of obstetrical work, the enormous responsibility represented in every case, no matter how normal it may seem, demands the attention of one who has been thoroughly drilled and who is thus in a position to recognize the possibilities in each and every case; who, in the event of emergency, can institute that therapy which will enhance the prognosis of both lives concerned. Consequently, all things considered, common sense, judgment, and modern day tendency towards progressive, preventive medicine demands and can permit of only one grade, one standard of excellence of all alike who would attempt the field of midwifery. If there is to be a legalized midwife, then make it imperative that she be consistently placed upon equal footing with the medical graduate, in meeting every requirement imposed upon him, academic as well as professional, before licensure to practice be granted; in other words, make her a physician. The time is ripe for proper, full, effectual legislation; let it demand, in justice to all, that license to practise obstetrics carry with it a full and thorough knowledge of obstetrics.

#### DISCUSSION OF DR. JAMES'S PAPER.

DR. MADDUX: I feel that Dr. James has touched upon a very practical and important subject and one to which the people of

this State have not given enough attention. It would be an interesting matter to know how many of the individuals practising mid-wifery in this State are really mid-wives, and how many are merely common nurses who call themselves mid-wives. We ought to consider what methods are practical and feasible to correct existing conditions. Any law that becomes part of the statutes should deal with the problem as it is dealt with in Germany, where licenses are issued for a brief period and the person who receives the license has her record of work, cleanliness, etc., subject to periodical inspection. I believe that measures should be taken to ascertain how many of the so-called mid-wives have had proper training. An act of legislature should be passed to restrain those who have not had training from acting as mid-wives. I would suggest that some resolution be passed by the Society in relation to this matter.

DR. DEITZ: In Germany the supervision of mid-wives is very strict and they are especially trained to know where their sphere ends and that of the physician begins. I think that Dr. James's idea that mid-wives should be educated as in a special branch of medicine is theoretical rather than practical. It presupposes that the mid-wife of the future will have a classical or academic education. Practising, as I do, in the coal regions, where we have a very large foreign population, it would be very difficult to enforce such a law. The question of cost is one of importance, and they are apt to call in any old woman they can get in an obstetric case. Measures that are proposed to remedy this condition are ideal. Whether they can be carried out is another proposition. It is well, however, that we should endeavor to improve the standard if possible.

DR. MADDUX: I wish it to be clearly understood that I did not mean to urge the enactment of a law to prevent professional mid-wives from practising, but I do urge that untrained mid-wives be restrained from attending obstetric cases. In order that the matter may be given careful consideration I move that the question of the regulation of mid-wifery be referred to a special committee. The motion was seconded and carried.



**BUREAU OF PEDOLOGY****J. M. HEIMBACH, M. D., Chairman****NUTRITION, AS AFFECTED BY NASAL, ORAL AND PHARYNGEAL  
CONDITIONS.****BY****I. D. METZGER, M. D., TYRONE, PA.**

(Read before Homœopathic Medical Society of the State of Pennsylvania.)

ALL created matter must be surrounded by the proper environment to maintain its entity and undergo its wonted as well as forego any unwonted change. In the inanimate world disintegration is constantly working destruction to every constructed material, reducing chemical combinations into their integral elements and producing new compounds. In the animate creation a spiritual phenomenon, known as vital force, automatically repairs the destroyed tissues and perfects them, providing the conditions are conducive to the same. Appropriative and assimilative processes are constantly quickened into activity, causing a multiplication of cells of their special kind until the law of limits halts the growth and the embryo has developed into maturity. In the vegetable world the stimulative effect of life is immediately withdrawn at maturity and decay begins. In animal life a state of equilibrium between waste and repair is maintained for a season until the limit of age operates against the vital force and decay hastily reduces the animate compound. Finally, the impending crisis supervenes and the spirit is liberated, leaving the body as an inanimate compound of marvelous instability. Thus we have the cycle of life.

The extent and perfection of a life depends largely upon the conditions under which it is developed. In plant life much more depends upon soil and atmosphere than upon embryonic vitality. The poorest seed-germ may result in a commendable plant-life while the choicest seed may develop into a stunted and unproductive parent-life. The environment is well known to predetermine the product and therefore becomes the chief study of the agriculturist. A striking analogy exists in human development. The sturdy tiller of the soil fairly glows with health and throbs with physical vigor while in his accustomed

environment, but soon sinks into ennui when removed therefrom. Cæsar recognized in the Gauls an unusual enemy because they were far removed from the devitalizing effect of the ancient Roman civilization. Modern civilization is attempting to rescue its devotees from these direful effects by persistently urging out-door life, exercise and proper hygiene. The chief matter of concern among educators now-a-days is to ascertain the best possible surroundings and pedagogical methods under which the growing body and mind may be developed. The ultimate product, a harmoniously developed body and mind, is constantly kept in view. Proper nutrition is the chief adjunct in securing this end. The oversight of this falls to the physician. Shall we loiter in this progress, or shall we lead in suggesting the best way of securing the acme of physical vigor and strength?

Can a person, by taking thought, add to his stature? Yes, methinks he can, if he or his guardian takes thought early enough in life. We cannot predetermine the form and limits of development which the quickening vital force shall assume, but by directing the influences which shall ply upon one's nascent being, we can in a large measure modify the ultimate product.

But, suitable environment is not the only essential to physical development. The application of the same to the human system is, for our consideration, the paramount issue. What means good food to him who cannot ingest and digest the same so as to secure its food value? or, what means exhilarating air to him who cannot flood his respiratory tract with its balmy breezes? In general, the proper correlation of environment to being largely predetermines the physical as well as the spiritual welfare. Here lies the educator's complex problem. The teacher who can get the child to grasp and utilize the beneficent qualities of his environment and exclude the malevolent ones, produces a being who will readily transcend his less fortunate, mediocre fellows.

Physical development is largely dependent upon two complex functional phenomena, the proper supply of oxygen to the blood through respiration and the proper application to the system of tissue-producing food material. Anything that hinders the several organs in performing these functions does to the same degree impair nutrition. A slight defect in the operative mechanism of your automobile may materially affect its

efficiency, and so a small abnormality in the mouth, nose, or throat may seriously affect the vitality of the child.

Impaired nutrition shows itself, (1) in the general appearance,—the child is stunted in size and has a thin, pinched facial expression; (2) in the quality of the blood,—a reduced number of red corpuscles and diminished percentage of hemoglobin; and (3) in the quality of the tissues,—soft, flabby and toneless, showing in the clumsy, shiftless and oft-times slovenly manner of the child. There is a probability of evidences of some constitutional disease, notably rickets, chlorosis, anemia, scurvy, or lithemia. The general resistance to acute infectious diseases is low, making such children favorite subjects for the propagation of these itinerant maladies.

The chief elements of nutrition, air and food, have their main avenues of entrance to the body, as everyone knows, in the nose and mouth. The chief respiratory channel is the nose, with the mouth as a subsidiary, compensatory one. In motion, air abhors acute angles but describes curves. The inspiratory air-current follows an elliptical course from the vestibule to the middle and superior turbinates, thence along the roof of the nose and beneath the sphenoid sinus to the posterior extremity of the inferior turbinate. Any obstruction along this course alone will seriously impede nasal respiration; marked deviations or enlargements elsewhere in the nose may not be of great consequence. Adenoids, abnormalities about the middle turbinates, especially about the "vicious circle" and about the ethmoid and sphenoid cells, will materially reduce the volume of inspired air. If the air be forced along the floor of the nose as its only nasal channel, it is apt to resort to the free oral entrance. In normal nasal respiration the air is warmed, moistened and cleansed. In mouth breathing, the air strikes the oropharynx and makes an abrupt turn downward, thereby greatly impeding its progress and reducing the amount of inspired air. To secure the proper curve desired by the air, nature elevates and thus provides the characteristic arched palate. Dry and altered condition of the pharynx, trachea and bronchi results from the effort of the air to extract moisture and heat from their lining. Therefore, any abnormality in nasal respiration causes the atmosphere to enter the delicate air cells of the lungs physiologically unprepared, and of inadequate quantity. The result is poor aeration of the blood, imperfect oxidation of the tissues, sluggish waste elimination,



and faulty tissue production. Moreover, the absence of nasal respiration exerts a marked influence on the circulation at the base of the brain; venous stasis results from the ethmoid veins not draining perfectly and hyperemia of the meninges is apt to occur. This lack of brain nourishment aids in making evident the aprosexia of the confirmed mouth breather.

The oral cavity normally is admirably adapted to the appropriation to the body of food. For this purpose, there are two chief functions, mastication with salivation and deglutition. Any interference with either is apt to affect the nutrition. A full cluster of teeth symmetrically set is most important. Freely acting muscles about the mouth and in the oropharynx are essential to both mastication and deglutition. Enlarged tonsils impede the action of the tongue, the soft palate, and the pillars,—palatoglossii and palatopharyngii muscles—so they cannot properly aid in controlling the bolus of food during chewing. The high arched palate, formed during the dentition period, is apt to cause poorly placed teeth. It also interferes with arranging the food between the teeth, and, when associated with mouth breathing, forms a suction which hastens the inclination to swallow. Thus, in his efforts to secure air, the unfortunate victim bolts his half masticated food into his stomach. The saliva is improperly secreted and poorly mixed with the food much is evaporated by the air current or lost by the pendulous jaw. Hence, we have started a course of indigestion which persists throughout the alimentary tract. Many of the cases of malnutrition are due, not so much to the lack of food, but to either the faulty appropriation of food or to improperly selected food. An hypertrophied lymphatic ring, also greatly impedes deglutition so that the child prefers to go from the food unsatisfied rather than undergo the agony of eating. As the age of the child advances the irregularities become accentuated so that the development of the oral cavity becomes permanently faulty. Possessing the requisite conditions, heat, moisture and suitable pabulum, the mouth is a fruitful nidus for the development of pathogenic bacteria. The perpetually enlarged lymphatic glands draining the oropharynx, found in many children, show the efforts made by the system to counteract the infections constantly breeding in this cavity. The recurrent inflammations which loiter in the adenoid growths augment their hypertrophy until the occlusion makes their removal imperative. Better to anticipate the devitalized and impover-

ished physical condition which is apt to supervene by the early removal of these offenders.

One of the chief essentials to nutrition is a high state of vitality in the system. The low ebb of energy in most children suffering from oropharyngeal defects, makes mere existence distressing. How can we expect them to thrive in development? Moreover, they become easy victims to dangerous diseases and feeble fighters in eliminating the same.

The vicious process which is invited by improper breathing in childhood, is nurtured in youth and results in permanent imperfections in adult life. These may be a bad catarrh of varying degree and intensity affecting the specialized mucous membrane of the respiratory tract. Various diseases of this system easily follow. But above all, there supervenes in the life of the person a condition of lethargy and indifference to the best physically as well as spiritually. He is readily satisfied with poor ventilation, bad hygiene, immoral surroundings and practices, unguarded food and drink,—all of which diminish his already waning vitality. He is apt to lose entirely his feeble grip on life; crime, insanity, and imbecility are lying in wait for him, making his latter days a natural sequel to the neglect and indifference of some one responsible for his early care.

Shall we contentedly observe such a procession of events in the lives of our patients? How about contributory negligence? Let us be alert to these consequences during the nascent period of our patients' lives, and thus protect them to the future as well as present. Let us see that every physical obstruction to proper nutrition be removed, and, as far as possible, that every external influence operating on them be for their welfare here and hereafter.

#### DISCUSSION.

DR. H. S. WEAVER.—I consider respiration one of the vital functions of life. Breathe properly and you will enjoy health. I think proper respiration is an essential feature especially in young children. As soon as a child breathes with its mouth open there is something wrong somewhere. It may be adenoids, hypertrophic rhinitis or deviated septum and should be carefully examined and relieved because a child to be healthy must breathe properly. I had this fact called to my attention some years ago by a very marked case of nasal obstruction, in fact it is the only case of the kind I have ever seen. It was due

to a bony malformation of the upper jaw involving the nasal cavities. Looking at the child she had apparently a perfect nose, yet, upon examination, there was a distinct bony formation occluding both nostrils. There was no communication with the posterior nares. I saw the child first when she was 14 years of age, a puny, delicate child with a tubercular spinal condition having a very marked curvature. I operated her and made an artificial nose, giving her free breathing space. She was then placed in the hands of Dr. Hammond and to-day she could come into this room and, if one did not know her, you would say she had a straight back. She is a young lady 21 years old and in perfect health. I am sure had she not been operated upon and received nasal respiration she would not be here to-day.

I do not believe every case of adenoids requires operation. If there are no constitutional symptoms, no interference with nasal respiration and the child has a few enlarged glands in the post nasal space I do not believe that child needs operation. But where it interferes with respiration or the nutrition I claim the only remedy is operation.

DR. DIETZ.—I have a general interest in this subject. There is a certain percentage of cases where adenoids will return even after successful operation. I ask myself the question, why do we have adenoids in a certain class of cases? It is very rarely we find adenoids in a healthy child. What is the reason these children with adenoids are mentally deficient? Is it altogether due to insufficient air supply? I do not think so. I think that with adenoids we have an internal secretion and the absorption of this secretion causes the symptoms.

There is one subject which has not been spoken of which adenoids cause, that is the difficulty in hearing in these children. This is due to pressure or direct development of adenoids about the eustachian tubes. When you speak to these children they will look at you and do not understand. They do not apprehend because they do not hear well. All of these cases cannot be operated upon for different reasons. I have found that using adrenalin in the nose on a cotton swab gives surprising results in some cases of hypertrophic nasal catarrh. These cases need constitutional treatment. By this I mean the homeopathic treatment. Dr. Weaver has spoken about agraphus. Dulcamara is a very good remedy because these cases are worse in damp weather. I never give it lower than the 30th x, and I am not afraid to go higher. Other remedies are the calcareas and teucrium.

DR. BOWIE.—I do not think it would be necessary to operate upon a large majority of these cases if the proper antipsoric



treatment was applied to cure the catarrh. They would not develop the obstruction in the nasal passage. I think if you will read Gurnsey's work on Obstetrics, especially that part devoted to children, you will find many hints there by way of preventing these disorders. He tells us to give the young child antip-soric remedies to prevent catarrh. The neglect of acute attacks of catarrh is the cause of enlarged tonsils. If we treat these catarrhal cases with the homœopathic remedy, *allium cepa* is one of the best, *dulcamara* another, then give the deeper acting remedy, many operations will be uncalled for. Where there is a real bony obstruction there is nothing else to do but remove it. Where the disease is one of the mucous membrane our remedies will relieve this disease.

DR. SCHANTZ.—I was very glad to hear this paper. One condition which I have had to contend with is this: a child is brought to me with adenoids and enlarged tonsils. The order from the school teacher is to have the child operated because of the fact the child is not doing well. Now, this puts us homœopaths in a peculiar position because we can accomplish certain results with our remedies. The general tendency to-day is to do a thorough extirpation of the tonsils and adenoids. I do not know what Doctor Weaver's opinion is, but I have always felt that the mutilating operations were unnecessary and that simpler operations, tonsillotomies, where we clear up the respiratory area, give the child good breathing, will, with the internal remedy, good food and pure air, accomplish all that is required. Recently I saw an article in which the writer recommended more conservative operative work upon the tonsils. Dr. Dietz has asked about the remedy and I would ask what is the general practice at this time as regards operation.

DR. VARNER.—I have come in contact with the same problem as Dr. Shantz. I had a boy in the school with tubercular glands. The school physician sent word that I should have them removed. I replied that I was treating the case and it was not his place to dictate what should be done. It is the school physician's duty only to call the parents attention to physical defects. A young physician just out of college has certainly no right to dictate the line of treatment to old and experienced physicians.

DR. WEAVER.—Dr. Dietz spoke of recurrence of adenoids. This is a fact. I think you will very often find these children have had one of the acute infectious diseases. I have frequently noticed this. Even if the child is thoroughly operated, if that child contracts any of the acute infectious diseases, where there is a certain circulatory disturbance in the pharynx very fre-

quently there will be a return of the adenoid growth. I think there are a good many cases where a small amount of adenoid tissue is allowed to remain high up. If there is a small portion missed it is very apt to take on renewed growth and this is especially true if the child contracts one of the acute infectious diseases. I had this experience in my own child. I operated upon him when he was two and one-half years old. After this he contracted a violent form of whooping cough. Following this I removed a larger amount of adenoid than before.

In reference to the homœopathic treatment of these cases, I do not think we are doing our full duty unless we treat them constitutionally afterward. I think many of the failures are due to a neglect of this.

In reference to the operation we are doing now, I would say that on the tonsils we do both operations. I do not do a tonsillectomy in all cases. I do not believe this is necessary. Where the tonsils have been diseased and where there has been a rheumatic infection, the only thing to do is to remove the gland entirely. We do not know the function of the tonsil. It probably has some function but if that tonsil is diseased we cannot get a healthy function. There are a number of cases coming to you with hypertrophy of the tonsils where they are interfering with proper breathing or causing deafness by pressure upon the Eustachian tubes. In these cases the tonsillotomy removes pressure and is sufficient.

DR. METZGER.—I appreciate the fact that this paper has been effective in bringing out a general discussion. When the chairman asked me to write for this bureau, he expressed the desire that I should bring out the effects of obstruction in the upper air passages upon nutrition, hence there were omitted many other serious effects which may result from these abnormalities.

Regarding the question as to whether every case showing hypertrophy should be operated or not, an unusual experience presented itself in the New York Ophthalmic Hospital several years ago. City school inspectors sent in children by the scores asking to be operated for adenoids and tonsils. The specialists in charge were conservative and turned back many as not proper cases for operation. Some of these were undoubtedly operated later by less discriminating surgeons.

If the tonsils crowd the upper angle of the pillars we have special reasons, I think, for removing them. They hinder the action of these muscles in mastication as well as speech. Furthermore, the pocket in this location seems to be a favorite avenue for infection.

Constitutional treatment certainly should follow the removal of these obstructions. We are then just getting ready to apply

our medicines to the case. Having removed the cause, we may expect curative results from the exhibition of our constitutional remedies.

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### REFLEX VOMITING IN CHILDREN.

BY

J. M. HEIMBACH, M. D., KANE.

(Read before the Homœopathic Medical Society of the State of Pennsylvania.)

VOMITING is a spasmodic ejection of the stomach contents through the oesophagus and mouth. The matter vomited may be normal or pathological. We can say that there is an immediate cause which is mechanical. The mechanical cause is due to an increase of pressure in the stomach from increased abdominal pressure and relaxation of the cardiac orifice simultaneously.

The intermediate causes are due to an irritation of the vomiting center itself by some stimulus or transmitted to it from the cerebral cortex direct or reflexly from other organs of the body.

The vomiting center lies in the medulla oblongata in close juxtaposition to the respiratory and cough centers. Any irritation of this center directly, or reflexly, or from the cerebral cortex, results in vomiting. The sensory nerves that furnish the stimuli that result in vomiting are principally the fifth, glossopharyngeal, and vagus; but vomiting may occur from stimulation of afferent nerves from many organs of the body, like the kidneys, intestinal tract, testicles, etc. Now, if we bear in mind the relation of these nerves to each other and the interchanging of filaments one with the other and the close proximity of their central origin, we can readily conceive how the vomiting center itself is excited into action.

Vomiting in children is a vague, indefinite, and frequent symptom. On this account it is unfortunate in some instances for a child to usher in an illness with this condition. Children vomit easily and the mother often thinks very little of it. The old nomenclature "bilious vomiting" is still a favorite among the laity and calomel and salts the first prescription thought of. The younger the child the more likely it is just a regurgitation due to overeating and of little consequence and easily deter-



mined if a careful anamnesis of the case is obtained, and, if possible, the vomitus examined.

Vomiting is frequently an act of self-defense in acute gastric irritation. The irritating substances are ejected before they have time to be absorbed into the system. Foreign bodies in the upper air passages and upper digestive tract are often dislodged and expelled. In laryngeal croup it often relieves the spasm and establishes free respiration. This is brought about through the reflex arc of the glosso-pharyngeal and the vagus. Where the sensory stimulation is not sufficient, as is frequently the case in croup, many physicians take advantage of direct stimulation with such drugs as apomorphine, ipec., etc.

We have, therefore, two great groups of affections that cause vomiting:

I. Reflex Group.—Where any sensory nerve conveys an impression sufficiently strong to the center in the medulla and reflects a motor impulse that causes vomiting.

II. Direct Group.—Where the center of vomiting itself is irritated or transmitted from the cortex.

This group can be subdivided according to Hect into cerebral, spinal, toxic, nervous, periodical, and habitual vomiting.

With these preliminary remarks to my paper it is readily seen that we cannot depend upon the mother's diagnosis of a mere case of indigestion, or so-called "bilious vomiting" when you begin your inquiry into your little patient's illness. It must not only be inquiry on your part, but thorough examination of the child as well. It is just as necessary to get the totality of the symptom complex to make a diagnosis as it is to make an intelligent homœopathic prescription.

Reflex Vomiting.—Vomiting is a frequent symptom in any gastric disturbance. Acute gastritis, caustic poisons, ptomatus, errors in diet; in fact, anything that will irritate the stomach wall sufficiently to set the reflex arc into motion will produce vomiting. This form of vomiting has more or less pain and tenderness in the epigastric region. Locate the pain by examination and don't take the mother's word for it, nor the child's either. They locate the stomach anywhere in the abdominal cavity. The whole abdomen is their stomach. It must always be definite knowledge that we must obtain.

It is not a difficult matter to examine the stomach contents for a general practitioner if he acquaints himself with a few reagents and gets to work. We don't need to be specialists to

do this work and yet become fairly competent in a very short time to do reasonably good and satisfactory work. You can use dimethyl-amido-azo-benzol solution for free hydrochloric acid test. Your phenol-phtalein for total acidity test; your alizarine for combined hydrochloric acid test; your hard-boiled egg albumin to discover pepsin; your milk to see that you have rennet. If you add to this equipment some deci normal sodium hydrate solution, a few beakers, a funnel, filter paper, and a burette you have all that is necessary for a general practitioner to do better and more exact work. It will help you to at least settle the question whether you have an actual gastric disease or a condition remote from it only mimicing stomach disorders.

Esophagus.—We can have vomiting from the esophagus in case of stenosis and subsequent dilation. A history of cauterization from drinking corrosive substances and gradual cicatrization, or the filling up of a diverticulum of the esophagus, or stenosis due to functional neurosis. In this kind the vomitus is unchanged. It contains no hydrochloric acid or any of the digestive ferments.

Vomiting is often one of the first symptoms in our acute infectious diseases, such as scarlet fever, measles, pneumonia, variola, and erysipelas and may be toxic as well as secondary in origin.

During last winter and spring we had quite an epidemic of measles and a large percentage of the patients vomited just the day before the rash made its appearance, or the first few days the rash was out. This, no doubt, was due to secondary involvement of the stomach. It was not a difficult matter to tell what was coming when you noticed the measley cough, the coryza, and the congested conjunctiva and a look in the throat often revealed the rash on the soft palate.

Congenital pyloric hypertrophy and stenosis should always be thought of in persistent vomiting in infants under four months of age. I recall a case in my earlier years of practice where a child vomited in spite of careful dietetic advice and prescribing, finally died in inanition with a diagnosis of marasmus on my part. There is no doubt in my mind but a fair percentage of so-called marasmus with vomiting in those early months of their existence are nothing more than pyloric hypertrophy and stenosis. Thomson and Pfaundler do not regard this as an organic condition but as an entirely spastic one.

This, no doubt, is true in some cases where the mother is highly neurotic. The spastic type may have intervals when they retain the food and then are suddenly taken with severe pain and visible peristalsis a short time after feeding, whereas in the hypertrophied type it is persistent. It is surprising how much they vomit and the force with which it is expelled, probably a good portion of it through the nose. That there is an hypertrophy cannot be denied. It has been demonstrated by a palpable tumor before operation or post mortem, and cases have been operated successfully in a number of instances.

As we go down the alimentary canal obstruction of any kind in the small intestines will produce pain, nausea and vomiting. The changed condition of the vomitus after the stomach is first emptied and the active visible peristalsis and borborygmus and inability to get a bowel movement by ordinary means makes it quite evident that the cause of the trouble is an obstruction.

Appendicitis in its acute form is ushered in with a sudden pain in the abdomen then nausea and vomiting followed by local tenderness and rigidity and elevation of temperature and leukocytosis. The above syndrome should always be in the above order. According to Dr. J. B. Murphy, if fever is first to make its appearance a diagnosis of appendicitis should be questioned.

It is particularly important to make an early diagnosis of appendicitis in children. It has been my experience that children have little resisting power to any infection of the peritoneum and a rapidly spreading peritonitis often results. I have in mind several cases where the appendicitis was decidedly masked by a marked peritonitis on my first visit, and death resulted a few days later. The parents thinking it was a case of indigestion.

Renal Vomiting.—When we take into consideration the intimate relationship of the renal plexus of nerves with the semi-lunar ganglia on each side of the solar plexus in the center, we can readily see how easily a chain of reflexes can develop that will mimic gastric irritation. Uric acid crystals in the pelvis of the kidney or a stone, hydronephrosis pyelitis from any cause whatsoever can easily set this reflex chain into action and produce persistent vomiting. While we are on this subject of renal vomiting, we might as well mention acute renal congestion or any condition where the kidneys are unable to eliminate the toxins from the system, where a condition of uremia



exists, we have nausea and often vomiting not so much of a reflex nature, but caused more by a direct stimulation of the vomiting center. This vomiting invariably persists until better kidney function is restored and better elimination established.

*Catarrhal Jaundice* produces vomiting in its early stage, which is primary, no doubt, but later if kept up portal congestion and toxic irritation plays a large factor in keeping up this symptom.

*Pharyngeal Vomiting*.—It is only during the last few years of my practice that I took particular notice of this form of vomiting and if the cause of vomiting does not stand out like a beacon light, revealing its origin I always examine the pharynx and its immediate surroundings. This form of vomiting is especially liable to occur in the morning, and I am often agreeably surprised what a few applications of iod. and glycerine over the visible pharynx and post nasal space will accomplish. How can we account for this reflex irritation? You only need to study the nerve supply of these parts and the co-relationship to the vagus and you readily grasp the situation.

The glosso-pharyngeal nerve supplies these parts. This nerve has in its course the petros ganglion which sends out filaments communicating with the pneumogastric. When we study the intimate relationship the pneumogastric nerve has with the facial, the gloss-pharyngeal, the spinal accessory, the hypoglossal, the first and second spinals and the sympathetic, we can account for some forms of reflex vomiting that would otherwise keep us guessing.

Otitis media fooled all of us more than once for a few days, and I dare say until a free discharge made its appearance at the external auditory canal. I had a case about three months ago, ten months of age, who started with restlessness, slight rise of temperature and vomiting. My first visit I concluded it was some gastric irritation from a dietetic error or reflex from teething. He had swollen and tender gums. He did not improve from my first prescription. The mother informed me that the child seemed to be worse in the night and frequently reached up to his right ear. A slight pressure under the ear while his mother was drawing his attention to something else evoked an earnest cry and left no doubt where the trouble was. A discharge in thirty-six hours confirmed the diagnosis. How derelict we all can be sometimes and take things for granted.

Eye strain can produce nausea and vomiting and should be thought of in obscure cases, especially in school children. A quick change in focusing for near and distant work and the time of aggravation occurring when there is most strain on the eyes usually leads you to the proper diagnosis and treatment.

Broncho-pneumonia is frequently ushered in with vomiting. Last March I was called to see an infant eight months of age, with vomiting and rise of temperature and the parents thought the baby was developing scarlet fever. After stripping the child and going over the case carefully, I felt very safe in telling the parents that the child did not have scarlet fever, but a well developed case of broncho-pneumonia or capillary bronchitis, whatever you choose to call it. The child continued to vomit a sort time after nursing until the chest began to clear up.

In the beginning of this disease we undoubtedly can call it reflex vomiting. In this case the child kept on vomiting so that it was no longer reflex, but due to irritation of the vomiting center direct from poor bronchial ventilation and coughing, the child always becoming more cyanotic while nursing. Ipec. relieved the condition after other remedies had been tried. In cases where there is a prolonged cough there may be considerable epigastric tenderness, where the recti muscles are inserted, from muscular strain similar to any muscular fatigue from prolonged use. Only a superficial examination would lead to error in such a case unless co-existing gastric symptoms as in tuberculosis would be present. Cough after eating often causes vomiting, and whooping cough should be suspected before the whoop manifests itself.

Violent coughing spells produced by any disease will lead to vomiting. The close topographical and functional relation the cough and vomiting center have to each other explains the reason.

*Peritoneum.*—In obscure cases of vomiting we should never fail to examine the hernial apertures that are accessible and bear in mind the possibility of retro-peritoneal hernias, kinking of the bowel, ileus, and volvulus. Sharp pains and shock with vomiting renders such conditions highly probable.

Intestinal stenosis of a slower onset such as a gradual accumulation of feces, foreign bodies, and invagination has vomiting. The same symptom complex manifests itself from an

attack of peritonitis through paresis of the intestines. Paresis of the intestines from other sources will likewise produce a similar condition. I had a case of infantile paralysis that vomited persistently and no bowel movement could be produced by ordinary means. Another doctor diagnosed obstruction and advised operation. I did not consider it advisable nor worth the effort. The other gentleman got the case and operated but found nothing to operate. The whole intestinal tract was paralyzed.

#### TEETHING.

Peripheral irritation of the fifth nerve from teething cannot be denied. We can however not blame all alimentary disturbances during the first few years in life to this frequent abnormal development of the teeth. The nervous system in such little infants is very unstable and their reflexes are very easily disturbed in various ways. It produces hypersecretion of the salivary glands and the stomach is not as tolerant as at other times. Vomiting often takes place from no other apparent cause. It is therefore advisable to examine the gums, and, if they are swollen and tender, they should receive proper attention whether it is the source of the trouble or not.

*Intestinal Parasites.*—Intestinal parasites cause vomiting in rare instances, and are even ejected at times. The hypersecretion brought about by the parasitic irritations may produce the vomiting. It is not definitely decided whether the vomiting and other nervous symptoms are reflex from the intestines, or brought about from the products of metabolism of the endozoa. I, myself, believe that it is reflex depending upon the amount of irritation they cause. The symptoms are intermittent. The child is to all outward appearances well and hardy for days or even weeks when all at once the storm breaks out again. Metabolic products would be absorbed and retained, and eliminated more constantly. Anthelmintic medication to expel the endozoa to make a diagnosis is no longer necessary. Microscopic examination of the feces reveals the presence of eggs.

A great deal more might be said about reflex vomiting and finer shades in differential diagnosis brought out. I hope the discussion will bring out such points that the time and intent of my paper would not permit. If I succeed in infusing more earnest, more painstaking, and more exacting work in the treatment of children's diseases I consider myself well paid for the



time and energy I consumed in writing this paper. This matter of being a physician and having in charge the little tots who are to become the future brawn and brain of our nations is indeed a serious business; for it is the health of our children individually that enables them to grow and develop the composite thinking and working men of generations to come.

#### DISCUSSION.

DR. C. S. RAUE.—Dr. Heimbach has covered the field of vomiting so well that there is very little for me to say. There is one form of vomiting that the Doctor has not mentioned, and that is cyclic vomiting, and I would like to say that this is a very important condition and usually not recognized the first time it occurs in a patient. Upon the first recurrence you will easily recognize the type. Treatment will have to be applied mainly during the intervals, in other words, it must be prophylactic. Cyclic vomiting may be confused with tubercular meningitis. There is nothing more puzzling than a case of vomiting continuing for a few days without any discoverable cause. In such cases you should be very suspicious of tubercular meningitis in its early stage. I have seen this so often that I am suspicious if I see a child vomiting and cannot find some distinct cause for it. There is one point that furnishes some information and that is the presence of acetone in the urine. For a while we were of the opinion that acetone in the urine in moderate amounts always appeared after protracted vomiting. Von Norden was responsible for this belief, but we now know that acetone may occur independent of starvation. In these cases of cyclic vomiting, if we examine the urine regularly, we may find acetone present even before the vomiting has occurred. When you get acetonuria early you may be sure you have not a case of tubercular meningitis.

**ACUTE BRONCHO-PNEUMONIA IN INFANTS.**

BY

ADELBERT D. DYE, PH. B., M. D., WILLIAMSPORT.

(Read before Homœopathic Medical Society of the State of Pennsylvania.)

THE carelessness of physicians in not watching closely enough their cases of bronchitis in babies, and the ignorance of parents, as to the seriousness of the complications frequently occurring in the acute infectious diseases, are the chief cause for broncho-pneumonia in infants.

This disease occurs most frequently during the first two years of life, and is most always secondary to bronchitis or following measles, pertussis, diphtheria and scarlet fever. Too many parents who do not like to have the yellow quarantine card on the house, will not call the doctor for measles, whooping cough, etc., until pneumonia has gotten its hold, and the baby weakened by the previous disease does not respond to the remedies given.

Children in unhygienic surroundings, institutions and asylums, and those suffering from rickets, marasmus, syphilis and gastro-enteritis pass from a simple bronchitis to broncho-pneumonia very easily.

The symptoms vary, and no text-book can give a typical case. In most cases one notices that the symptoms of the primary disease are getting worse. The fever will go up, the pulse rate increase, and the respiration rise to 60 or 80. The cry becomes weak, and, an expiratory grunt characteristic of lung involvement will be heard, there may be a severe cough. The child may refuse all food and vomit whatever it does take. It will generally be thirsty, and the mother will speak of how much water it will take. The tongue will be dry and coated. If the involvement increases the breathing becomes shallow, and the lips and finger nails blue.

If the fever remains high, stupor and coma will appear, and the medicine cannot be swallowed. Convulsions may develop at the end, or the respiration gradually becomes shallower, and at longer intervals.

The physical examination will show the labored breath with a pause between inspiration and expiration, coarse, moist rales will show the bronchitis and crepitant and sub-crepitant rales.

and diminished breathing over a limited area will show the pneumonia involvement.

The digestive tract is generally affected, and the abdomen is frequently bloated, so as to interfere with respiration. Frequently vomiting is one of the first symptoms with loose diarrheic bowel movements.

The prognosis is usually unfavorable, because of primary illness. The younger the child, the less are its chances for recovery, as is the case also with the artificially-fed babies in institutions and asylums.

The high mortality rate for this disease will not be reduced until the parents realize that measles, whooping cough, etc., lead to more serious complications, and call the physician before the pneumonia condition has developed.

The child should be kept in bed in a light, airy room, a room in which the windows can be opened without a draft blowing on the bed. If the cough is dry, the air should be kept moist, by means of a croup kettle or dish with the water steaming.

A daily cleansing bath should be given and the temperature can be reduced, when too high, or causing restlessness and sleeplessness by the cool sponge bath, or alcohol rub. The position of the child in bed should be changed to prevent hypostatic congestion.

When the temperature is sub-normal in weak, poorly nourished infants a hot mustard bath should be given, taking the child out when the skin becomes reddened from the irritant action of the mustard.

Compresses wrung out of the water at 90 degrees, can be placed on the chest, and frequently changed without disturbing the patient.

Ice bags to the head in cases where the fever produces delirium may be used with caution.

I do not believe heavy poultices should be used on the chest, but flannel or cotton jackets should be worn. The bowels should be moved by a mild laxative, or by rectal enema. If the stomach is disturbed, the feeding should be modified, and possibly suspended, using barley or rice water.

In breast-fed babies, the intervals of nursing may be lengthened. Water should be given freely.

The condition of the heart should be watched carefully. A rapid, weak pulse, with feeble heart sounds and signs of failing compensation, call for stimulation. Strychnia and nitro-



glycerine alternated every two hours, have produced good results with me. Alcoholic stimulants, such as brandy must be used well diluted and for only short periods, for they disturb the stomach.

Inhalations of oxygen should not be left to the last, as often it will produce good results, if used early enough.

Aconite is usually the first remedy thought of, if the case can be seen early enough, especially, if the physician is called to see the child in the beginning of the measles, whooping cough, etc.

You will see a patient who has a fever, is restless, does not want to be touched, full, tense pulse, and hot, flushed face. If the patient is not restless, but quiet with a frothy, blood-streaked expectoration, ferum phos. would be indicated.

If the pulse is slow, soft and weak, the eyes blood shot, the face congested, and signs of cerebral congestion, veratrum viride would be the remedy. When the case has developed farther, and signs point to the lung involvement, such remedies as bryonia, phos., ant. tart., carbo. veg., ipecac, lycopodium, cheledinum and arsenicum will be thought of.

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THE BRAN CURE OF CONSTIPATION. This old and valuable remedy is highly extolled by A. Ernest Gallant (*New York Medical Journal*, August 31). He says: "Among the several hundred patients whom we have taught the bran habit, there have been many who suffered with chronic diarrhoea, alternating diarrhoea and constipation, mucous colitis, enema constipation, constipation due to the use of castor oil, the saline waters and other drugs whose secondary effect is an astringent one and results in relative constipation." He feeds convalescing post-operative patients (even after celiotomy) a daily quota of bran and teaches them "the value of this beneficent habit." The best results have been obtained by the use of coarse, unground, raw bran, once or twice daily—one to four tablespoonfuls stirred in a glassful of cold water and quickly gulped down, or mixed with cooked cereal and eaten with milk and cream. Many prefer to take it stirred in soup, puree, bisque, broth or gruel, and children like it mixed with jelly, jam, marmalade, honey, maple or other syrup, and spread on bread or toast. When taken just before going to bed, it should result in an action before the morning bath. If taken at breakfast, "a natural though mild alarm will be felt about noon, and this warning should always be promptly obeyed or the good effect will be lost." It may be necessary to continue the usual cascara or phenolphthalein lavative for a few days only.

## EDITORIAL

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### THE MEDICAL CRISIS IN ENGLAND.

DOCTORS are proverbially poor business men and it is seldom that, either as individuals or as a profession, they give much consideration to the financial side of their work until dire necessity forces such consideration upon them. It is sometimes possible, however, to learn wisdom from the experiences of others and, if such is the case, the physicians of America would do well to seriously consider the condition in which the medical profession of Great Britain finds itself.

About a year ago the Government passed a National Insurance Act which provided for free medical care of all persons who came within the provisions of the Act. The compensation that the Government proposes to make to physicians in return for their services amounts to a mere pittance, and if the terms of the Act are carried out as proposed, it will mean that at least fifty per cent. of the medical practitioners will be reduced to such straits that they will have to abandon the practice of medicine.

The British Medical Association has attempted to enlist the co-operation of all physicians in order to secure just compensation from the Government for the services of physicians, but as usual, many physicians are unwilling to co-operate in this movement, and the efforts of the Association have been only partially successful.

If the demands of the profession are met, it will call for an increase of twenty million dollars annually over the terms which the Government originally proposed and so far the Government has been entirely unwilling to consider this proposition. The members of the British Medical Association have recently broken off negotiations with the Government and are endeavoring to secure pledges from the physicians of Great Britain not to accept positions under the Act.

In order to avoid granting the demands of the British Medical Association, the Government is now considering the organization of a national medical service with full time physicians on a salary. This would require about fifty-five hundred medical men to care for the fifteen million persons who will be

beneficiaries of the new Insurance Act. It is not difficult to secure the services of physicians at a low salary, and such a plan would be entirely practicable. What would become of the remaining twenty-four thousand physicians in Great Britain under such circumstances is easy to foresee, and it is probable that if the Government announces its intention to proceed along these lines, the members of the British Medical Association will be forced to abandon their fight and to accept the original terms offered by the Government. In either case the outlook for medical practitioners in Great Britain is very discouraging.

G. H. W.

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### ACONITE.

A SHORT time ago a group of members of the American Medical Association, who have constituted themselves a "Court of Last Resort" on questions relating to the usefulness of medicinal agents, decided that cactus, echinacea and a number of other well tried clinical remedies were useless, and recommended that they be dropped from the materia medica. We now learn that Mr. F. W. Price has reported to the Therapeutic and Pharmacological section of the Royal Society of Medicine of London, that his investigations upon the action of aconite show that it has no influence whatever in slowing the pulse and that he believes the remedy is one which possesses little value.

This result of "scientific investigation" comes as a jolt even to the clinicians of the old school, who, influenced by the remarkable results obtained from the administration of aconite in the practice of homœopathic physicians, have employed the drug for many years and have had ample opportunity to witness its beneficial effects when administered in proper cases, and almost every writer on materia medica or therapeutics has testified to its value. In fact it may be questioned whether there is any remedy in the materia medica that has won a more legitimate place for itself than aconite. Now, we are asked to discard this remedy entirely because Mr. Price finds that it does not slow the pulse and therefore "possesses very little value."

Even Dr. Hobart A. Hare, whose work on the physiological action of drugs has won for him an international reputation, cannot accept this summary dismissal of aconite without a protest. In an editorial in the *Therapeutic Gazette*, he states that



the results of Mr. Price's experiments are directly contradictory to those which have been generally accepted as correct. He further states that "It is possible that aconite may not act to produce beneficial results in the way that has been generally received, but this does not prove that it does not produce good results when properly administered in suitable cases."

We conclude from these statements that investigations of the physiological action of a drug by different investigators, all presumably competent, are likely to yield diverse and even contradictory results and, furthermore, that Dr. Hare believes that aconite *does* produce good results when properly administered in suitable cases even though the manner in which it acts may not be properly understood. Whatever conclusion may be drawn from the experiments of Mr. Price or of others as to the effect of aconite upon the pulse rate, the fact remains that when aconite is administered in suitable doses in accordance with the indications laid down by Hahnemann more than one hundred years ago, its administration is followed in almost every instance by a prompt and satisfactory relief of the symptoms and in many cases by a rapid and complete cure.

We do not wonder that Dr. Hare protests against this attempt to dismiss aconite as a useless remedy because the experimental evidence of Dr. Price fails to confirm the generally accepted old school ideas as to the physiological action of this drug. As a clinician, he is too familiar with the beneficent therapeutic results obtained from the administration of this remedy, to be willing to abandon it on such vague theoretical grounds. Our only wonder is that he and other practical physicians are willing to discard such remedies as cactus, echinacea and others for reasons no more satisfactory or convincing.

G. H. W.

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#### IMPORTANT ANNOUNCEMENT.

IN reply to certain queries and comments that have come to our attention in connection with the publication in the November issue of the HAHNEMANNIAN MONTHLY of the list of medical colleges whose graduates are eligible for medical licensure in the State of Pennsylvania, we desire to state that this list was published at the request of and under the direction of the Board of Medical Education and Licensure of the State of Pennsylvania for the information of medical schools and of students of medicine.

G. H. W.

**EXAMINATION QUESTIONS—BUREAU OF MEDICAL EDUCATION AND  
LICENSURE OF THE STATE OF PENNSYLVANIA.**

*Tuesday, December 3rd, 2 P. M.—Physiology, Pathology, Bacteriology.*

1. State what an examination of the blood would elicit in: (a) anæmias (primary, secondary and pernicious), and (b) leukæmia. Give in detail the technique in making the blood examination for these conditions.
2. Given a case of bronchopneumonia (catarrhal pneumonia), detail the local conditions, the etiology (in cases where the process is infectious) and state the effect on the normal functions of the lungs and metabolism.
3. Given a case of acute parenchymatous nephritis; name the pathological conditions present in the kidneys and state how these conditions would interfere with the normal functions of the kidney. Name the abnormal organic constituents that might be found in the urine in this disease.
4. Describe any one lesion of the liver showing how this lesion interferes with the normal functions of the liver and the effect of such interference upon digestion.
5. Describe the lesion in tabes dorsalis (locomotor ataxia) giving the usual cause and show how this lesion interferes with the normal functions of the cord.
6. Name two of the more usual diseases that may have as sequelæ endocarditis, resulting in an organic heart lesion: show how in the case of any one such organic heart lesion the normal functions of the heart may be interfered with.
7. Name and describe two pathological lesions which may have as a symptom, hæmatemesis. What information might an examination of the stomach contents give in differentiating the above conditions?
8. Differentiate as far as possible typhoid fever from appendicitis by means of laboratory tests.
9. In carcinoma of the tongue name the usual variety. Describe its gross and its microscopical appearance and give the avenue and usual point of metastasis.
10. In severe ulceration of the cornea what changes may occur in the structures involved and what disturbed function may be permanent. Name three micro-organisms most frequently found and outline a method of detecting and differentiating them.

*Wednesday, December 4th, at 9 A. M.—Diagnosis, Symptomatology, Medical Jurisprudence and Toxicology.*

1. Enumerate the symptoms and give the prognosis of cerebro-spinal meningitis (spotted fever) in a child; differentiate this disease from tubercular meningitis.
2. Enumerate the symptoms of chronic interstitial nephritis; differentiate it from diabetes insipidus.
3. Enumerate the symptoms of cancer of the pylorus; differentiate it from two other diseases of this region, which may simulate it.

4 Enumerate the symptoms diagnostic of acute inflammatory rheumatism; differentiate it from tubercular joint disease.

5. Enumerate the typical symptoms of inherited syphilis; (a) symptoms at birth, (b) early symptoms after birth, (c) later symptoms.

6. Enumerate the symptoms of herpes zoster (shingles) and differentiate it from pemphigus.

7. Enumerate the symptoms of epidemic parotitis (mumps), name the complications and sequelæ, and differentiate it from one other condition, which may resemble it.

8. State the symptoms of lead poisoning, and differentiate it from alcoholic paralysis.

9. Differentiate the toxemias of septicemia and uremia

10. State briefly from a legal standpoint (American law), (a) what constitutes rape, (b) what constitutes indecent assault.

*Wednesday, December 4th, 2 P. M.—Gynecology and Obstetrics, Hygiene and Preventive Medicine.*

1. What are the dangers of abortion (criminal, during the first three months); in case of such abortion how may these dangers be overcome?

2. Given a pregnant woman (the first three months) of doubtful intra-uterine (normal) or extra-uterine origin, describe in detail how you would determine the correct diagnosis; in case it proved to be extra-uterine pregnancy how would you treat the case? (omit descriptions of operations).

3. Should you be called upon to deliver a woman at full term of pregnancy, discuss the status of the use of the vaginal douche, the use of an anesthetic and the use of ergot.

4. Should a woman with a deformed pelvis (early in pregnancy) engage your services, by what various means might you aim to secure her a living child? In each instance (method) what would be the limits of measurements of the conjugate-vera (true)?

5. If a woman in labor should suddenly develop the symptoms of collapse or shock, name three causes which may be responsible for the condition. How would you recognize the one present, and how would you manage the case in event of each of the three causes? (omit description of operation).

6. How would you deduce the presence of uterine cancer: (a) early, (b) late in a patient? State the various methods of treatment (omit descriptions of operations).

7. What dangers may threaten the eyes of a new born infant? Discuss the prophylaxis and treatment in such a case.

8. Given a room just vacated by a person suffering from a serious infectious disease, by what methods would you treat the room and how soon would you allow the room to be occupied? Describe the method in detail.

9. Should a house become contaminated with sewer gas, what are the dangers to inmates? What steps would free the house from gas? Detail the means of preventing its re-contamination.

10. What dangers attend the proximity of stables to dwellings? How are these dangers guarded against? What methods should attend the disposal of the manure?



*Thursday, December 5th, at 9 A. M.—Anatomy and Surgery.*

1. What are hemorrhoids? State varieties and the blood vessels involved in each. Outline two methods for the cure of hemorrhoids.
2. In fractures of the clavicle, state the anatomical reasons for the displacements of the fragments.
3. Enumerate the injuries that might be received from a fall upon the outstretched hand; outline the treatment of any two forms selected.
4. Enumerate the various forms of abdominal herniæ; outline the technique for the correction of any one form, giving the surgical anatomy of part selected.
5. State the conditions that might require trephining the skull: outline the technique of this operation.
6. In the case of collections of fluids within the chest; outline two surgical methods for relief, with reasons for selecting each.
7. What are the early symptoms of hip joint disease? And what is their anatomical explanation?
8. Outline two methods for the cure of ulcer of the leg. State conditions that tend to aggravate or perpetuate ulcer of the leg.
9. Describe the ambulatory treatment of a sprained ankle.
- 10 Enumerate the various forms of fracture that might occur at or about the elbow joint; state the appropriate splints for three of the more usual forms of these fractures, with reasons for selecting each.

*Thursday, December 5th, at 2 P. M.—Chemistry.*

1. a. Give the chemistry involved in the digestion of fats in the intestinal tract.  
b. What is a fixed oil?  
c. What is a volatile oil?  
d. What is glucoside?  
e. What are ptomains?
2. a. What is iodine?  
b. From what source is it obtained?  
c. Describe its physical appearance?  
d. In the secretion of what gland of the human body is it found?  
e. Describe a test indicating its presence in any medium?
3. a. What is the composition of the atmosphere?  
b. Give the average percentage of each component ingredient.  
c. How is that state of equilibrium maintained?  
d. What would be the effect on human life confined in an atmosphere containing 15 per cent. of carbon dioxide?  
e. How may carbon dioxide be detected in expired air?
4. Give a chemical antidote for the following substances:  
a. Morphine.  
b. Nitric acid.  
c. Ammonia water.  
d. Arsenic  
e. Oxalic acid.
5. Name and make diagrams of five different crystalline substances that may occur in urine.

Thursday, December 5th, at 2 P. M.—*Therapeutics.*—(*Medical Society of the State of Pennsylvania.*)

1. Give the average dose for adults and at least one therapeutic application of the following official preparations:

a—Liquor Arseni et Hydrargyri Iodidi.

b—Liquor Ammonii Acetatis.

c—Liquor Iodi Compositus.

d—Liquor Potassii Arsenitis

e—Liquor Potassii Hydroxidi.

2. Write two prescriptions in the Metric System, each containing 120 cc. Select only official or National Formulary remedies: Prescription No. 1, to meet the needs of a case of atonic dyspepsia.

Prescription No. 2, a hypnotic for a case of delirium tremens. Give full directions as to dosage and frequency of administration.

3. Give the official name, together with dose, of two drugs of each of the following classes:

a—Anodynes.

b—Expectorants.

c—Heart Stimulants.

d—Alkaline Laxatives.

e—Emetics.

4. Outline the treatment you would employ in a case of acute articular rheumatism, covering every symptom, which in your opinion, should receive attention.

5. Give the sources of the following remedies and describe their therapeutic action:

a—Cantharis.

b—Apomorphinæ Hydrochloridum.

c—Fel Bovis.

d—Oleum Morrhuæ

e—Hexamethylenamina.

Thursday, December 5th, 2 P. M.—*Therapeutics.*—(*Homoeopathic Medical Society of Pennsylvania.*)

1. Give the indications for the use of Ignatia Amara in conditions of the nervous system; compare and contrast Hyoscyamus and Belladonna.

2. Compare and contrast Drosera, Rumex, and Phosphorus in affections of the respiratory tract.

3. Give in detail the pathogenic action of Arsenicum Album upon the intestinal tract.

4. State the indications for the use of Cantharides in conditions of the genito-urinary tract; compare and contrast the use of Terebinth and Cannabis Indica in similar conditions.

5. For what peculiar conditions, and for what subjective and objective symptoms has Sepia Succus been found a helpful remedy in the special disorders of the female.

*Thursday, December 5th, 2 P. M.—Therapeutics.—(Eclectic Medical Society of Pennsylvania)*

1. Enumerate the conditions, in which you would prescribe Echinacea; give its physiological action and specific indications.
2. What are the specific indications for Arsenic; describe in detail its therapeutic action and uses; also its physiological action.
3. Give the specific indications for Aconite, Veratrum, Gelsemium, Belladonna and Ergot. Detail the therapeutic uses of each one and dosage of same.
4. Name five remedies which are used in diseases of the female reproductive organs, and give the specific indications for each one.
5. State the therapeutic uses of Ignatia and Nux Vomica, and give reasons for selecting each one

CLINICAL SIGNIFICANCE OF REGULAR TACHYCARDIA.—T. Lewis notes that there are forms of this condition. The first is the simple or physiological type of tachycardia. The other two forms are subdivisions of a single class—namely, the pathological type of tachycardia; they may be termed simple paroxysmal tachycardia and auricular flutter. The increase in the heart rate that occurs as the result of exercise, emotion and fever, and that occurs in exophthalmic goiter, in chronic alcoholism, pulmonary tuberculosis, and other toxic conditions, is of the same nature in all of these cases. The rate of impulse formation in the region of the superior vena cava is increased, and both auricles and both ventricles participate in the altered rate. Whatever the mechanism, the fact remains that this is a simple exaggeration of a normal phenomenon. How is an acceleration of the heart's action of this type to be recognized? The heart-rate falls conspicuously when the patient lies down, it rises when the erect posture is re-assumed, and it is increased by exertion and by excitement. Electrocardiograms provide a valuable and the only method of estimating whether an individual heart beat has been propagated along normal channels or not. If the beat arises in an abnormal center the course of the contraction wave is necessarily altered and the beat gives rise to an abnormal type of curve. The second kind of tachycardia is of this type and includes the pathological forms of tachycardia; it arises, not at the normal center, but at some point away from it, and the new center is usually an auricular one. It occurs in short or long paroxysms, whence the term which describes it. But these are not the sole characteristics of this form of tachycardia, although they are among its chief ones. When simple tachycardias come and go, they come and go gradually; the pathological types of tachycardia appear and disappear abruptly. In auricular flutter, the third type of tachycardia, the rate surpasses 200, the maximal known limit being 335 per minute. The new rhythms arise in the auricle and probably away from the normal center; they also start and finish abruptly; they are also uninfluenced by posture, exercise, and other similar factors to a remarkable degree. Auricular flutter, besides being characterized by the greater rapidity of the heart beat, differs from the former group of cases in two respects: Although the rate of auricular contraction is extreme, being usually between 270 and 300 per minute, it is but rarely that the ventricle keeps these paces. In most instances this chamber beats at half the auricular rate, and the grade of acceleration is thus disguised.—*Med. Record.*



## GLEANINGS

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DIAGNOSIS AND TREATMENT OF PRURITIS.—There are no specifics for itching, says Dyer, but there are medications in particular diseases which may apply for general use, of course individualizing the case in hand. Arsenic is the prime treatment for the nervous forms of the disease, and its administration is largely corrective of the itching. The derivatives of wheat and oats may aid in these types and the tincture of *avena sativa* (wild oats) is of special usefulness, given in conjunction with the arsenic. Where there is no neuropathic cause or association, the arsenic not only does no good, but it may actually do harm by local over-stimulation. Strychnin serves excellently in the vasomotor disturbances with itching. Zinc phosphid acts similarly, and is of special service in chronic itching diseases. *Cannabis indica*, in the fluid extract, may be used every hour in five-drop doses; as soon as the acute itching is controlled, the dose may be reduced and the period of administration lengthened to every three or four hours. Chlorid of calcium is of service in senile pruritus and in all itching where there is any suggestion or evidence of lowered coagulability. Freshly prepared chlorid of calcium may be administered in 5 to 15 grain doses, well diluted and repeated every three or four hours. Antipyrin and salicylate of soda, used in combination, serve best in gouty subjects or in uric acid cases. The use of the sodium and potassium citrates, at the same time, materially aids in the treatment. Gelsemium, codein, *veratrum viride*, bromids, chloral hydrate and chloroform are among the anti-spasmodics which have good effect in stopping the paroxysms of itching, but any and all of these may be relegated until the above named drugs have been first essayed. The too free use of morphin for itching should be condemned. With all cases of pruritus, mild laxatives, diuretics, mineral waters of alkaline sorts, diet restrictions and limitations by injunction, habits, etc., should be carefully weighed and considered where indicated.

The local treatment of pruritus is of considerable importance and needs to be suited to the particular case. General baths are of supreme service in the treatment of itching, and these should be taken as hot as can be comfortably borne. Such baths may be employed in all diseases or conditions in which itching is general. The baths may be plain or may carry such emollients as starch, marshmallow or bran (in bags), or alkalies may be added, such as carbonate of soda (3ss to 3i to 30 gallons of water), household ammonia (3i, 3ii to the 30 gallons), or sulphuret of potassium (3ii, 3i to the bath), the last named being especially indicated in all parasitic diseases, vegetable or animal. Wet dressings may be substituted for the general bath, when the itching is so localized as to permit of such. The dressings should be kept wet with saturated boracic acid solution, 1-5,000 to 1-10,000 mercuric chlorid solution, 1 per cent. phenol solution, 1-5,000 potassium permanganate solution, or 1 or 2 per cent. solutions of resorcin, in water always. Fixed dressings of coal tar made into a felt

with superimposed cotton may be applied and left in place for days at a time. Even dry cotton may be firmly bound in place, when such a dressing can be so fixed that the patient cannot remove it easily.

Oily substances may be employed and the old-fashioned carron oil may be used, or camphor and chloral hydrate. Cocoa butter and cocoanut oil are excellent protective applications when the skin is dry. An oily substance of excellent antipruritic value in small areas may be derived by combining phenol, menthol, camphor and chloral hydrate, and this may be diluted with any of the simple oils. Itching of the anal area is frequently relieved by ergot, used either in ointment made with the fluid extract or in suppository with the solid extract. Intestinal parasites should be excluded or removed. Genital pruritus is often helped with weak resorcin solutions. The use of the high frequency spark over the sacral plexus is an excellent adjuvant for genital pruritus and a systematic general effluve will often aid when other remedial agents fail. All cases of pruritus should be studied as individual types, and the etiology should be determined when possible; then the way to cure will be easier.—*Dr. L. Dyer, Jour. of Arkansas Med. Society.*

**GROCCO'S SIGN IN PLEURITIC EFFUSION.**—This sign, which, as is well known, consists of a triangular area of dullness, paravertebral in position, situated on the side of the chest opposite the effusion, proved itself in the author's experience, practically constant in cases with free fluid in the pleural cavity or in which an encapsulated effusion impinges on the spine.

With the patient lying on the affected side the triangle either greatly diminishes or disappears (except in those rare instances where the pleura is enormously distended, to reappear when the patient reclines on the opposite side or assumes the sitting or standing position.

The paravertebral dull area does not form a perfect triangle; the hypotenuse is usually a curved line, particularly at the upper portion. Its size in general varies with the amount of fluid in the pleural cavity, but right-sided effusions are usually accompanied by a somewhat larger triangle than those on the left.

The sign is of particular diagnostic aid when the amount of fluid present is small. It must not, however, be regarded as pathognomonic, as evidence is accumulating to the effect that the triangle may be present in a number of subphrenic conditions associated with the massing of fluid.—*Mark A. Brown (Lancet-Clinic, June 15, 1912.)*

**CARDIAC COMPLICATIONS OF PREGNANCY.**—F. S. Newell states that while the strain of pregnancy is generally well borne by the normal heart, any organic lesion in this condition calls for constant watchfulness on the part of the medical attendant, even though it may be perfectly compensated under ordinary conditions. Pregnancy occurring in such a case, with imperfect compensation, calls for immediate emptying of the uterus, since the already disabled heart has no chance of sustaining the added burden. When failure of compensation occurs during pregnancy attempt should be made to restore it by rest and appropriate treatment, and if this does not succeed the pregnancy must be ended and future pregnancies be forbidden. In cases with demonstrated heart lesions, even if they have given no trouble during pregnancy, labor should be regarded with apprehension

and every effort made to shorten it. A patient with a compensated organic disease usually stands operation well, but operation after failure of compensation will often be disastrous. A patient with organic heart disease and contemplating marriage should be warned as to the risks of pregnancy and labor, the prognosis in each case depending on the nature of the lesions, the age of the patient, and her previous history as regards the behavior of the heart under normal conditions. It is impossible to estimate accurately the efficiency of the heart-muscle after failure of compensation, since, although it may have been restored under treatment, death may occur suddenly before, during, or after labor. Labor should be shortened as quickly as possible whenever demonstrated organic lesions exist, although they have caused no unfavorable symptoms. In primiparae the propriety of Cæsarean section, which may relieve the strain on the heart, may well be considered, especially with rigidity of the soft parts. Mitral stenosis calls for most careful observation. Any sign of failing compensation should be met promptly and if anything occurs accompanied by a rise in arterial tension the pregnancy should be terminated at once.—*Journal American Medical Association.*

ARTERIOSCLEROSIS, TREATMENT OF.—Discussing this subject from the standpoint of physiological methods, the author states that in the employment of rest and massage the best results are obtained when the patient is put to bed for two or three weeks. The rest should be nearly absolute, though the patient may take his customary sanitary bath daily. He should have forty minutes of general massage daily by a competent operator. The author reports a case in which these measures led to a reduction of 26 mm. in the systolic and 8 mm. in the diastolic pressures; these results, however, were not permanent.

The diet of these patients should be a mixed one consisting of easily digestible food, with a fair amount of residue, and moderate in amount. Breakfast should comprise fresh fruit, one egg, buttered toast, and milk or buttermilk. Dinner should consist of cream soup, a small piece of roast beef, roast lamb, roast or boiled mutton, roast or stewed chicken or very fresh fish, one baked potato and one other vegetable, a small helping of salad, and a simple dessert. The evening meal should be light, consisting of broth, bread and butter, buttered or milk toast, milk or buttermilk, custard, junket, cornstarch, rice or tapioca pudding, or fresh or stewed fruit. In the middle of the forenoon and afternoon the patient may have a glass of milk or buttermilk.

Hot or tepid full baths both reduce blood-pressure temporarily. In addition, the hot full bath promotes elimination of toxic material and nitrogenous substances by the skin.

Carbonated brine (Nauheim) baths should not be given in cases of arteriosclerosis with high blood pressure, particularly when there are indications of nephritis. They tend to raise the pressure, and in one patient referred to appeared to contribute in bringing on a uremic attack.

In cases complicated by asthmatic attacks or by subacute or chronic bronchitis the Russian bath is of value

The electric light bath is of great value in arteriosclerotics, both robust and thin. In the robust its effect can be continued for from one-half to



one hour by a blanket pack, and in the latter a spray should be given after ten minutes spent in the cabinet. An hour's rest in bed should follow.

It is to be observed that all of the methods described, except the tepid full bath, produce sweating, and that after each treatment a period of rest is advised. In the author's opinion it is the sweating and rest which yield the benefit in these cases rather than any other obscure factor.

As for the autocondensation method of applying a high-frequency current, the author states that it may reduce blood pressure, but that great care is necessary in employing it.

The passage of the high-frequency current through a vacuum tube, with the production of ultraviolet rays, has a considerable value in the cutaneous anesthesia, hyperesthesia, or paresthesia of arteriosclerosis. It seems to be of greater value than either faradism or galvanism.—*Swan (New York State Journal of Medicine, July, 1912.)*

VALUE OF THE LEUCOCYTE COUNT IN ACUTE SURGICAL DISEASE.—By Dr. Herbert W. Hewitt (*Surg. Gyn. and Obst.*, February, 1912.)—The total count he considers as of little value, as it is influenced by many factors, notably the following:

A. Physiological Leucocytosis: (1) leucocytosis of the new born, (2) leucocytosis of digestion, (3) leucocytosis of pregnancy, (4) leucocytosis after parturition, (5) leucocytosis of violent exercise, (6) leucocytosis of cold baths and massage, (7) terminal leucocytosis.

B. Pathological Leucocytosis: (1) posthemorrhagic, (2) inflammatory, (3) toxic, (4) malignant diseases, (5) due to therapeutic and experimental influences.

The following statements, the author considers, may be followed as safe general rules:

1. The total count is an index of the patient's resistance to the infecting organism.
2. The relative polymorphonuclear count is an index of the degree of, or severity of, the infection.
3. If we have a relative polymorphonuclear count ranging between 75 per cent. and 80 per cent. infection is probable; if between 80 per cent. and 85 per cent. infection is almost invariably encountered, and this regardless of the total number of leucocytes. In fact, some laboratory workers do not make use of the total count at all, but depend for diagnosis entirely upon the differential count.

A few points can usually be decided by reference to both counts, namely: (a) Bodily resistance, whether high, or low. (b) Infection, whether severe or mild. (c) Infection whether well borne or poorly resisted. (d) Infection whether circumscribed or diffuse (*e. g.*, appendicial abscess).

Can we place the percentage of polymorphonuclear cells at a certain number below which we do not expect to find infection? He quotes Sondern, in this respect, as follows: "A relative percentage of polymorphonuclear cells below seventy with an inflammatory leucocytosis of any degree excludes the presence of pus or gangrene at the time the blood examination is made, and usually indicates good bodily resistance toward infection."

In the writer's opinion, in acute inflammatory surgical diseases repeated

counts at frequent intervals should be made, and if the polymorphonuclear percentage rises while the total number remains stationary or falls, immediate operation should be insisted upon.

From this study the author draws the following conclusions:

1. The laboratory findings must be correlated with the clinical to be of any value at all.
2. The total count alone is insufficient.
3. The differential count, *per se*, is of value in diagnosis, but of little value in prognosis.
4. The total and differential counts, when taken together and correlated with the clinical findings, are frequently of great value both in diagnosis and prognosis.
5. No definite percentage of polymorphonuclear cells can be taken to positively indicate infection. If we have a percentage of between 75 and 80 of polymorphonuclear cells, infection is probable; if we have a percentage of between 80 and 85, infection is usually found; if we have a percentage above 85, infection is almost invariably encountered.
6. The duration of the infection must be taken into consideration.

Counts are most positively diagnostic when taken early in the course of an acute surgical disease. Infection will frequently, when of long duration, overcome the patient's resistance and so vitiate the value of the count.

THE DIAGNOSIS OF GALL STONES.—The symptoms produced by gall stones will vary considerably, in their intensity, in their variety and in their importance and they will correspond very closely to the lesions which they represent. Unfortunately the clear cut classic picture of gall stone colic is rare rather than common, and unfortunately the public and the majority of the medical profession hold the mistaken view that the less severe symptoms which are usually found do not point out serious danger and do not necessarily call for surgical relief.

Some cases present classic textbook pictures. In these the diagnosis is simple. The cardinal symptoms are acute violent pain coming on suddenly, usually at night; this pain is stabbing, lancinating in character, and it radiates to the back and right shoulder. There is usually tenderness, sometimes very acute in the region of the gall-bladder. Frequently there is vomiting and if the attack lasts for a day or two there may be jaundice. The attack may be ushered in with a chill or there may be a succession of chills. Such cases present but little difficulty in diagnosis.

The vast majority of cases are not manifest by a severe and characteristic attack and diagnosis is not forced upon us but it should always be made if we pay attention to the whole picture of the case and if we hold the view that chronic indigestion and dyspepsia are not normal conditions. In the majority of cases the gall stones are at rest and are not causing active and violent irritation. The gall bladder and bile ducts are chronically but not acutely inflamed. Symptoms will correspond to these conditions and will be those of a slight localized irritation, of a slight inflammation of a chronic type and of a slightly disturbed function on the part of the digestive tract. They are mostly those of a chronic dyspepsia, not violent in character. Such patients will have sour eructations, belching of gas and a sense of fullness and tension after

eating. They may have slight pains, slight tenderness and rigidity at the Mayo-Robson point. They usually suffer from constipation. These are the cases where diagnosis is certainly not easy. In some the diagnosis must be inferred. These patients should be carefully watched and if their symptoms are sufficient to disturb their health, to undermine their nervous system or make useless or unhappy their lives they should certainly be operated upon, assuming that they have had careful hygienic treatment without success.

Let us here consider the co-relation of certain diseases of the stomach, the biliary tract, and the appendix. There are many cases which present symptoms of dyspepsia or chronic indigestion in which it would be impossible to say whether the lesion is in the appendix, in the bile passages, or in the pylorus or duodenum. These cases are to my mind of the utmost importance, and yet the vast majority of them are neglected by the medical profession. They are cases in which there is a vague sense of distress in the right upper quadrant of the abdomen, acidity of the stomach, eructation, and belching of gas, slight tenderness over the region of the gall bladder, a sense of distension or upward pressure, sometimes irregular looseness of the bowels, usually constipation. Now, if such patient does not show an active attack of appendicitis with localized pain, tenderness and rigidity or a classic attack of gall stone colic with a violent pain radiating to the back or shoulder, with vomiting, chills and jaundice, or the positive evidence of gastric or duodenal ulcer made up of violent pain, vomiting and hemorrhage, I say, if such a patient does not show such positive and unmistakable evidence of one of these conditions, he is almost invariably neglected by his physicians; and yet I maintain that every such case of incurable indigestion is due to one of these three diseases, namely, peptic ulcer, gall stones, or chronic appendicitis. And I also maintain that every one of these patients should be cured. Gastric and duodenal ulcers may be cured by a medical treatment in a certain proportion of cases, when they are not thus cured and permanently cured they should have surgical relief. Chronic appendicitis and gall stones are never cured by any except surgical means.—(Syms—*New York State Journal of Medicine.*)

INDUCTION OF LABOR WITH THE CHAMPETIER DE RIBES BAG.—Broadhead (New York) has published his experience with this procedure in 139 cases, published at length, and has found that sizes two and three are the most useful. Accidental rupture of the membranes occurs in about 3% of cases. In about 90% only two bags were needed, in nearly 70% only one bag was required, in 6% labor failed of induction. Anæsthesia is not necessary. In 37% labor begins at once, in 70% within twelve hours, in 88% within thirty hours. The average length of time intervening between the insertion of the bag and the onset of labor is eight hours in primiparæ, and ten hours in multiparæ. In primiparæ the average duration of labor was twenty-two hours, in multiparæ sixteen hours approximately. In 5% the presentation was changed, but in only one case was the outcome affected. In 4% the cord prolapsed, which is low considering that many of the operations were required for contracted pelvis. In private cases the fetal mortality was 5%, in hospital cases 11%. The maternal mortality was nil.—*Amer. Jr. Obs.* Vol. 65-753.

THEODORE J. GRAMM, M. D.



ASEPTIC OR ANTISEPTIC HANDS IN OBSTETRIC PRACTICE.—Stewart (New York) in an article wherein he says that he has simply given the results of his experiments without loading down a paper with statistics, and every step of the experimentation leading to the paper has been careful and painstaking and may be readily duplicated, says that the vagina is a sterile canal and to reach it we pass through a contaminated ring, the vulva. To do this by introducing an aseptic finger means contamination of both finger and canal. To introduce an antiseptic finger means the contamination of neither. Therefore the antiseptic finger or hand is the best for obstetric purposes.—*Amer. Jr. Obs.* Vol. 65-61.

THEODORE J. GRAMM, M. D.

BACILLUS LACTIS BULGARICUS IN INTESTINAL CONDITIONS OF CHILDREN.—Clock (New York) says that Metchnikoff has shown that it would be possible to arrest the growth of putrefactive bacteria by introducing cultures of lactic acid bacilli into the intestines. The bacillus lactis Bulgaricus has been found to exert a most profound effect upon the putrefactive bacteria; and is the only lactic acid bacillus known that will survive ingestion, reach the large intestines, and continue to live there, creating nascent lactic acid, which is antagonistic to the growth of pathogenic bacteria. Applying the knowledge that the growth of one organism will inhibit the growth of another, the writer experimented with various preparations supposed to contain the bacillus lactis bulgaricus, but secured no definite result; most of the preparations on the market consisting chiefly of paralactic bacilli. Through the Johns Hopkins Hospital a pure culture of the bacillus lactis bulgaricus has been imported from the Pasteur Institute. This culture is dried and mixed with milk sugar and compounded into a tablet. The cases reported by the writer show the results obtained with this new method of treatment in bottle-fed babies. Some of the cases were of the most severe type of gastro-intestinal disturbance, but a decidedly favorable result followed in every case. The gastric symptoms quickly disappeared, the toxæmia subsided, mucus and blood disappeared from the stools, which lost their offensive odor; indigestion cleared up, and the stools became normal in color and consistency on the third or fourth day; and no return of the intestinal condition followed in any case. The treatment consisted solely in the administration of the tablets above referred to. Twenty tablets were given in twenty-four hours to infants of five or six weeks of age. After the stools became normal the dried culture was administered three times daily for a period of one or two weeks.—*Amer. Jr. Obs.* Vol. 65, 911.

THEODORE J. GRAMM, M. D.

ECLAMPSIA AND ITS CONSERVATIVE TREATMENT.—When one really considers the present status of eclampsia the unfortunate situation in which physicians find themselves becomes apparent. Ferguson's article accentuates the fact. He says: "The physician who is called upon to meet the emergency of a puerperal convulsion is compelled to choose a treatment that is at once condemned by a large number of eminent and recognized authorities. He knows that in the event of a fatal outcome to child, mother or both, he will meet the criticism of a large number of

intelligent physicians. He will spend many uneasy hours weighing the pros and cons for various treatments for any of which he can find high authority, and, what is most disquieting, equal condemnation. In this article the various theories are placed in exasperating contrast, and then the author says whatever our theory, treat the disease we must. At the very outset we encounter two diametrically opposed methods of treatment relating to obstetric intervention. Immediate evacuation of the uterus is very widely advocated, and yet Herman, of London, declares that the patient is not benefitted thereby and supports his assertion by an analysis of 2,000 cases. Hirst has cited 260 cases of his own in which both plans were tried, and concludes that any form of accouchment force adds to the risk and increases the mortality. The author emphasizes the importance of the premonitory signs and of prophylactic treatment. Persistent headache or rise in blood pressure call for active catharsis, rest and a milk diet. Disturbed vision should be treated with catharsis and sweating. Diuretics are ineffective until the vicarious action of the skin and bowels have relieved the kidneys. Parathyroid extract is used because the gland is believed to produce an antitoxin which destroys or counteracts the effect of toxins incident to the pregnant state. The administration of calcium salts or a diet rich in them meets the recent theory of abstraction of calcium salts by the growing fetus whereby fatty infiltration and degeneration of liver cells is induced. For the eclamptic seizure the author mentions effective elimination by packs, hypodermoclysis, proctoclysis by the Murphy method, croton oil or epsom salts, morphia, one-quarter grain repeated every thirty minutes until the deep sleep is produced. The latter, though not universally advocated, has reduced the mortality one-half. Chloral in 20 grs. doses is mentioned. If in labor, the rupture of the membranes gives marked relief by lowering the blood pressure. The author then reports three cases successfully treated by these means.—*Amer. Jr. Obs.* Vol. 65-437.

THEODORE J. GRAMM, M. D.

CARCINOMA OF THE UTERUS.—The conclusions drawn by Stacy (Rochester, Minn.) from a consideration of this subject cannot be too frequently emphasized. They are: Cancer in its early stages is removable and hence curable. Cancer of the uterus usually gives symptoms in this early, operable stage. Most of the deaths from cancer are due to delay, either on the part of the patient or of the physician first consulted, and are, therefore, unnecessary. The laity should be made to realize that any irregular flow, a constant bloody discharge, or a watery discharge are not due to "change of life," but in practically all cases, mean malignancy. The laity must be taught that cancer is curable if operated early, i. e., while still a local disease. Physicians should make an early and careful examination and give the proper advice without delay.—*Amer. Jr. Obs.* Vol. 65-946.

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**The Place of Operation in the Treatment of Uterine Fibroids.** By Edwin A. Neatby, M. D. London. The Homœopathic Publishing Co., 12 Warwick Lane, E. C. 1911.

The little monograph in which the author places before the profession his grounds for the conviction that early operation should be urged in the treatment of uterine fibroids, is a very creditable work from every standpoint. The author gives complete records of one hundred cases that have come under his personal observation, and describes the result obtained in each. Aside from the scientific value of the work, the original colored illustrations, of which there are several, reflect great credit upon the publishers. Dr. Neatby's work is a very valuable and scientific addition to medical literature.

**Tuberculous Diseases of Bones and Joints, Their Pathology, Symptoms and Treatment.** By Sir W. Watson Cheyne, Bart, C. B., Professor of Clinical Surgery at King's College Hospital, Senior Surgeon to King's

College Hospital, Consulting Surgeon to Paddington Green Children's Hospital, etc. Oxford Union Press. American Branch, 35 West Thirty-second street, New York.

In the introduction to this volume, the author states that he has been struck by the alteration which has been taking place in connection with the question of operative treatment of tuberculous diseases of bones and joints. He believes that the modern treatment of tuberculosis has shown that the outlook in surgical tuberculosis is much more favorable than was formerly supposed and that operative treatment is not so frequently demanded. The contents of the work cover tuberculous diseases of the synovial membranes, of the cartilages and of the bones. Due consideration is given first, to the histology and pathology of tuberculous processes followed by chapters on "The Curability of Tuberculosis," "General Principles of Treatment," etc. The author then takes up the various joints of the body, seriatim, and describes the special mechanical and surgical means to be employed in their treatment. The wide experience of the author in the treatment of the diseases presented in this work, has enabled him to give original and authoritative information on the subject and the work will prove an invaluable one to physicians or surgeons interested in this subject.

**Diseases of the Digestive Canal** (Oesophagus, Stomach, Intestines). By Dr. Paul Cohnheim, Specialist in Diseases of the Stomach and Intestines in Berlin. From the Second German Edition. Edited and Translated by Dudley Fulton, M. D., Assistant Professor of Principles and Practice of Medicine, University of California College of Medicine, Los Angeles Department. Illustrated. Price, \$4.00. Philadelphia and London. J. B. Lippincott & Co.

The first English edition of Cohnheim's work proved such a decided success that the publishers have been called upon to issue a second edition. Those who are familiar with the contents of this work will not be surprised at the call for a second edition, as there are few works now before the profession of a more distinctly practical character than the present volume. The author frankly disclaims any attempt to review literature or to compile the views of others or to present pathological details and theoretical discussions. He simply gives the reader those facts of diagnosis and treatment that he has found by long experience, to be of value in the management of the diseases of the digestive canal. In the present edition, the editor has emphasized the increasing value of the X-ray in the diagnosis of diseases of the digestive organs and a number of new plates and illustrations have been introduced. We have found this work a reliable and valuable guide in the practical management of stomach and intestinal disorders for a number of years and commend it highly to any one desiring information along these lines.

**"The Prescriber," a Dictionary of the New Therapeutics.** By J. H. Clarke, M. D.

This little book, by a well-known English author, published by the Home Publishing Company, of London, England, and now in its seventh edition, is familiar to the profession on both sides of the water. To the mind of the reviewer it is the most complete and satisfactory work of this sort now before the profession giving as it does an essay on homœopathy, full information on case taking, the size and frequency of the doses and other essentials for the young practitioner and the lay prescriber.

# Pennsylvania State Society News

## JOURNAL COMMITTEE

D. P. Maddux, M. D.

Harry S. Weaver, M. D.

Ralph Bernstein, M. D.

**Pennsylvania's Opportunity.** What a splendid opportunity for Pennsylvania to show her loyalty and devotion to the cause of homœopathy at the coming meeting of the American Institute of Homœopathy, to be held at Pittsburgh in June of 1912. Surely, Pennsylvania, with its fourteen hundred physicians—seven hundred of whom at least endorse their State Medical Society, can be depended upon to make a formidable showing at the Institute meeting. It has been said by Pennsylvania's critics, and perhaps justly so, that Pennsylvania in the past has been lacking in its endorsement of the National Society—the Institute. This may have referred entirely to the lack of members in attendance at the Institute meetings. Surely it has not referred to the number of Pennsylvanians endorsing the Institute by their membership. The 1910 report shows that there are at least two hundred and sixty-four names of Pennsylvania homœopaths upon the membership roll, which compares more than favorably with the number upon the roll from Pennsylvania's close State neighbors. There is no reason, however, why Pennsylvania should not out-do all of its neighbors, or all of the States in the Union for that matter, in the number of members upon the roll of the Institute. Surely if there are fifty per cent. of them who endorse their State Society, there is no reason why that same fifty per cent. should not endorse their National Society. It should be Pennsylvania's aim and pride, between this time and the Institute meeting, to see that such a state of affairs will exist by the coming June. Perhaps it is merely the fact that the membership has not been properly solicited. If such is the case then Pennsylvania's membership committee in the past has been at fault. Perhaps Pennsylvania's membership committee for this year will see fit to take upon itself to form a thorough organization and outline a campaign for new members for the Institute which will count. Last year's State Membership Committee put in one hundred and twenty-seven new members, which was a record-breaker in itself; the best, in fact, in the history of the State Society. Surely this can be done for the Institute, and there is no logical reason why it should not be done.

**The New Medical Examining Board,** recently appointed by the Governor, will hold its first session presumably at the college in May, examining the juniors for their first two year's work, and the seniors for their final right to practice medicine, acting on the recommendation of the faculty of the college as to those who should be examined. Governor Tener on December 1st named the members of the "one board" medical examining organization, officially known as the Bureau of Medical Educational Licensure, as follows: For the homœopathic school, Dr. G. A. Mueller, of Pittsburgh, in the West, and Dr. Daniel P. Maddux, of Chester, in the East. For the allopathic school, Dr. Adolph Koenig, of Pittsburgh, and Dr. John M. Baldy, of Philadelphia. For the eclectic school, Dr. C. L. Johnstonbaugh, of West Bethlehem; Dr. Samuel G. Dixon, Com-



missioner of Health, and Nathan C. Schaeffer, Superintendent of Public Instruction, were appointed as members ex officio. The new board will succeed the State Medical Council and the examining boards representing three State societies in charge of the supervision of medical education and examination of applicants for licenses to practice medicine and surgery in Pennsylvania. The new board was created by the act of June 3, 1911; will have offices in the capitol, and conduct examinations at places it may designate.

Ralph Bernstein.

**The Clinico-Pathologic Society of Philadelphia**, held its regular monthly meeting at Hahnemann College on Saturday evening, November 18, 1911, at 8.30 o'clock. The first feature of the program for the evening consisted in the presentation of a number of interesting clinical cases, which was followed by the reading of two able papers on the following subjects: "A Case of Linitis," H. L. Northrop, M. D.; "The Ocular Manifestations of Diabetes," F. O. Nagle, M. D.

B. K. Fletcher, Secretary.

**The Philadelphia Society for Clinical Research**, held its regular monthly meeting on Wednesday evening, November 15, 1911, at the Colonnade Hotel, at 9 P. M., being entertained by Dr. F. B. Quackenbush, the title of whose paper was the "Treatment of Rheumatic Fever." Dr. Percy Tindal as well presented a paper on the "Hygiene of the Eye." This meeting was also the occasion of the presidential address.

John F. Rowland, M. D., Secretary.

**The Homœopathic Medical Society of the 23rd Ward, Philadelphia**, was entertained by the Secretary of the Society, Dr. John D. Boileau, 804 West Lehigh avenue, on the occasion of its regular monthly meeting on Wednesday, November 15th. The paper for discussion presented by Dr. Boileau was on "Refraction," and hearty discussion was entered into.

**The Delaware County Homœopathic Medical Society**, held its regular monthly meeting on November 9, 1911, at 3.30 P. M., in the Y. M. C. A. Building, Chester, Pa. Dr. Edward S. Haines, of Morton, Pa., addressed the Society on "Medical Ethics." Dinner was served at 5 P. M.

**The Women's Homœopathic Medical Association of Pittsburgh**, held its regular meeting at the office of Dr. Mary E. Coffin, 3823 California avenue, N. S., Pittsburgh, on Thursday evening, December 7th, at 8.30 P. M. The scientific program consisted of a paper on "Coughs and Colds, with Repertorial Study," by Dr. Ella D. Goff, while the subject of Dr. Coffin's address was "Carroll Dunham." The meeting was well attended.

Mary E. Coffin, M. D., Secretary.

**The Women's Southern Homœopathic Hospital**. The Board of Managers held a unique bazaar, "The Carnival of the Seasons," in Horticultural Hall on Wednesday and Thursday, November 22nd and 23rd, for the benefit of the new building fund, the new building being in course of erection at Broad and Fitzwater streets, Philadelphia. Luncheon was served from 12 to 2, and dinner from 6 to 8 P. M. In the evening the Planet Junior Chorus Association furnished music for the occasion.

**The West Philadelphia General Homœopathic Hospital**. Four nurses were graduated at the fourth commencement of the institution on Tuesday, December 5th, the graduates being Miss Helen Gertrude Weyers,

Miss Miriam Wolff, Miss Matilda M. Fischer and Miss Anna M. Yeager. The exercises were held in the West Park Presbyterian Church, and were opened with Scripture reading by the Rev. C. G. Hopper. Dr. W. N. Hillegas, chief of the medical staff, delivered the address of welcome. A vocal solo was rendered by Mr. Percival S. Strauss, which was followed by an address to the nurses by Dr. Landreth W. Thompson. Mr. William E. Marbaker, president of the board, made the presentation of diplomas, and Mrs. George P. White, president of the Women's Board of Managers, presented the nurses with their class pins. Following the exercises a reception was held in the hospital for the relatives and friends of the nurses.

**Tri-County Society Meeting.** The Holiday Meeting of the Homœopathic Medical Society of Chester, Delaware and Montgomery Counties was held at the Colonnade Hotel, Philadelphia, corner of Chestnut and Fifteenth streets, Tuesday, December 12, 1911, at 1 P. M. J. W. Mullin, M. D., Wilmington, Del., read a short paper on "That Sacred Prescription." President J. W. Pratt, M. D., of Coatesville, opened the discussion and delivered his inaugural address. H. P. Leopold, M. D., Germantown, spoke on "Post Operative Treatment of Abdominal Cases." After dinner the President of the State Society, G. J. Palen, M. D., and William Speakman, M. D., made a few remarks.

Isaac Crowther, M. D., Secretary.

**The Clinico-Pathologic Society of Philadelphia,** held its regular monthly meeting at the Hahnemann College, on Saturday evening, December 16, 1911, at 8.30 o'clock. Program: 1. "The Ocular Manifestations of Diabetes," F. O. Nagle, M. D. 2. "A Case of Lymphatism," R. S. Leopold, M. D. 3. "A Case of Hemorrhagic Pancreatitis with Fat Necrosis," S. W. Sappington, M. D. 4. "Double Malignancy in the Same Organ," A note on two cases, J. D. Elliott, M. D.

Benj. K. Fletcher, M. D., Secretary.

**The Hahnemannian Medical Society,** of the City of Reading, held its regular monthly meeting on Thursday evening, December 7th, at 9 P. M., at the Homœopathic Hospital. Dr. Chas. R. Haman, the President, in the chair. The paper of the evening was presented by Dr. Wm. A. Haman, entitled "Contributions to the Therapeutics of Angina Pectoris." The attendance was unusually large and a hearty discussion was entered into.

Frank H. Lawrence, Secretary.

**The Hormones and Hormone-Therapy,** especially the peristaltic hormone of Zuelzer, known as hormonal, a specific physiological therapeutic agent in chronic constipation, intestinal atony, and the post-operative forms of intestinal paresis, are subjects at present in the very foreground of interest. Schering & Glatz, New York, have published a forty page brochure entitled "Hormone Therapy with Special Reference to Hormonal (Peristaltic Hormone—Zuelzer)," of which they will be pleased to mail a copy to every physician who makes request for the same.

**Location for Physician.** For rent, after December 1, 1911, double offices of the late Dr. L. D. Tebo. Offices completely furnished and fully equipped with appliances and books. Excellent location and good opportunity for a doctor. Address Mrs. L. D. Tebo, 200 Farnsworth avenue, Bordentown, N. J.

**Personals.**—Dr. O. A. Vroom, formerly of Doylestown, Pa., has removed his office to 2425 Columbia avenue, Philadelphia.

Dr. D. P. Brown, announces his removal to 76 Prince street, Bordentown, N. J., where his hours will be 7 to 9; 1 to 3; 6 to 8. He will be at his Crosswicks office 4 to 5 daily.

Dr. Mary Davis Ridgway, of Germantown, attended the banquet of the Child Welfare Conference at the Bellevue-Stratford. Dr. Ridgway has long given special attention to welfare work among children. She is chief surgeon of the Florence Crittenton Mission, of Germantown.

Dr. John P. Craig announces the location of his office and residence at No. 427 East Broad street, Chester, Pa. Hours, 8 to 10 A. M., 6.30 to 8 P. M., and afternoon hours by appointment.

Dr. Samuel Sappington, of Philadelphia, has been elected registrar of the Hahnemann Medical College in place of Dr. J. E. Belville, resigned.

**Evidence Beyond Argument.** Recognition of pharmaceutical preparations in standard works puts doubt and uncertainty immediately out of court, and the busy practitioner makes no mistake in recommending and ordering such recognized preparations in his practice, knowing that back of his prescription stands experience and authority; for example, when we find the following reference in Sutherland's "System of Diet and Dietetics," "Benger's Food, the Most Valuable Proprietary Food on the Market," and when the Australian Government goes further, and says, "To tax Benger's is to tax sickness," such statements must be given serious consideration, and the doctor or nurse who has not found Benger's a veritable "sheet anchor" in dietetic treatment, has not yet come to the last word in diet. From infancy to old age, whether it be in the home or hospital, Benger's has made good, as one doctor writes us, "Benger's Food surpasses and absolutely supersedes all other foods and humanized milk."

**The Medical and Surgical Club of Baltimore**, held its regular meeting at the Hotel Emerson, on December 13th. Dr. Leon T. Ashcraft, of Philadelphia, delivered an address on "Renal Tuberculosis." Following the scientific session a banquet was served at which a number of prominent physicians of Baltimore and vicinity were present.

**Marriages.**—Dr. and Mrs. Charles L. Dey, Crosswicks, N. J., announce the marriage of their daughter, Miss Helen S. Dey and Dr. David Posey Brown, (Hahnemann, 1901), on November 22, 1911.

Mr. and Mrs. Frank C. Johnson announce the marriage of their daughter, Myrtle Mae, to Dr. S. Anson Hill, Tuesday, December 20, 1911.

**Atonic Indigestion** demands the most vigorous tonic treatment available. For many years, Seng has held a unique place as a gastro-intestinal tonic and under its use the most far-reaching benefits are obtainable in all functional diseases of the stomach and intestines.

**Obituary.** Dr. Wm. H. Somerville, of 1214 East Columbia avenue, Philadelphia, died on the fifty-fifth anniversary of his birth. Dr. Somerville was born in Philadelphia and graduated from Hahnemann Medical College in 1881. Among the societies of which he was a member are Vischer Medical Society, Germantown Medical Society, and the Homœopathic Medical Society of the County of Philadelphia.



# FELLOWS' SYRUP of HYPOPHOSPHITES

A uniform result may always be confidently  
expected from this faithfully-prepared and  
long-tried preparation

*Reject* < Worthless Substitutes  
Preparations "Just as good"

Michigan Advances the Requirements to Meet the Demands of Certain State Boards and for Other Reasons. It is realized at Michigan University that an advance must be made in the requirements for entrance to medical college. For scientific reasons this is justifiable. For prudential reasons it is imperative. Eight or more of the prominent States of the Union now refuse to recognize as medical students matriculates lacking in a year of academic study before entering upon medical studies. Some of the States are demanding two years of such preliminary study. If our colleges are to maintain rank the country over, this move is necessary.

Students wishing to combine thoroughness with their medical science will be attracted by the colleges that are first to satisfy such wishes. Michigan has all the time offered for six years' study the degrees of B. S. and M. D. The advancement of requirements for matriculation to one year for all matriculates carries no promise of anything but a diploma from an adequate college, a part of a university with world-wide reputation for scholarship. The six year privilege also stands as before. The year of pre-medical work must include biology, chemistry, physics and enough language to round out a full college year. This can be taken in any good college or the entire five years may be taken at the University, the first consisting of registration in the department of literature and science and the pursuing of the required studies.

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**To the Members of the International Congress of 1911, and to all Physicians Practicing Homœopathy.**

Dear Colleagues:—The whole world is the province of homœopathy. This was the dominant idea in our International Congress. No cause has finally prospered until the artificial barriers of race and country have been set at naught. A Welt-Politik in the interests of greater homœopathy was, therefore, inaugurated during the Congress session.

The ancient fallacy of the water-tight compartment left homœopathy where it found it—a series of insular units. All civilized countries are not alike in the place and power gained by the Law of Similars. Here, it mounts with wings like eagles; there it makes but tardy pace with laggard foot. In every State or country where homœopathy is established against odds, it demands all the support which the more powerful establishments can lend it.

The machinery for the co-ordination and furtherance of homœopathic interests the world over has been set up. But the dynamic in full blast is required. An International Council will meet during the present year. Each country has its own representatives in this Inter-Congressional Council. Every homœopathic society, every homœopathic journal, every homœopathic physician throughout the world can and should think out, for the instruction of the international representatives how homœopathy can be best made to grow.

We want the weak places to be made strong, the rough places plain. The inspiring spirit of such a world-movement, bringing van, flank and rear into co-operation, is "Each for all and all for each." Homœopathy is not a historical expression, nor a geographical location. Again, the whole world is its province.

The American representatives on the Inter-Congressional Council are

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IS INDICATED IN  
**CATARRAL  
CONDITIONS**

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INTESTINAL  
STOMACH, RECTAL  
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### American Institute of Homoeopathy

**T**HE meeting at Narragansett Pier demonstrates that the Institute has taken its rightful place before the nation. The Government has given Homoeopathy official recognition. The full benefit to our school from this action can be had only with the continuous co-operation of Institute members in its work. The meeting for 1912 will be held at Pittsburgh, Pa., during the third week of June. Begin *Now* to plan your attendance.

All possible information can be had from the Secretary.

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659 ROSE BUILDING, CLEVELAND, OHIO



among the best brains that guide homœopathic affairs. We beg for them the individual aid and support of all who seek to make homœopathy progress.

Yours fraternally,

George Burford,

President of the International Congress of 1911,

John P. Sutherland,

Permanent Secretary of Congress.

Charles E. Wheeler,

Assistant Secretary of Congress.

**Notice.** A physician, who will conclude hospital service as resident, is desirous of doing relief work for a physician from June until November, 1912. Physicians desiring to go on their vacations during this period of time and anxious to have someone attend to their routine of duties will kindly address F. L. B., care of Hahnemannian Monthly.

**Medico-Chirurgical Society of Central New York.** The thirty-second regular meeting of the Medico-Chirurgical Society of Central New York was held on Thursday, December 7, 1911, at Syracuse, N. Y. The following program was presented: Morning Session, 10.30, "Diphtheria," Dr. J. R. Young, Liverpool; "Homœopathic Treatment of Rheumatism," Dr. J. T. Wallace, Oneida; "Report of a Case," Dr. W. E. Deuel, Jr., Adams; "Clinical Report," Dr. John N. Lee, Rochester; Address on Materia Medica, Dr. G. I. Bidwell, Rochester; "Early Diagnostic Methods in Tuberculosis," Dr. M. W. Johns, Utica; "Pleurisy with Effusion," Dr. W. L. Potter, Homer. Afternoon Session, 2.00—"Prostatectomy," Dr. Leon T. Ashcraft, Philadelphia; "The Union of Schools," Dr. H. R. Arndt; "Sectarianism Passing Away," Dr. E. E. Keeler, Syracuse; "Clinic," Prof. Leon T. Ashcraft.

**Auxiliary Alumni Association of Hahnemann Medical College Organized.** On Thursday, December 14th, the Western Pennsylvania Auxiliary of the Alumni Association of Hahnemann Medical College, Philadelphia, Pa., was organized in Pittsburgh. After the adoption of the Constitution and By-Laws, the following officers were elected: President, W. F. Edmundson, M. D., Pittsburgh; Vice-Presidents, J. B. McClelland, Pittsburgh; I. D. Metzgar, Tyrone; J. M. Maurer, of Washington; Secretary, Clyde W. Sample, M. D., Wilkinsburg; Treasurer, W. B. Bogges, M. D., Pittsburgh; Executive Member, Geo. B. Moreland, M. D., Pittsburgh.

The following Western Pennsylvania Hahnemann Alumni were present: Drs. J. E. Ambler, G. F. Baer, A. L. Baker, H. L. Baker, W. B. Bogges, P. S. Bolsinger, B. F. Books, E. P. Clark, W. H. Cooper, E. W. Dean, M. H. Dinsmore, W. F. Edmundson, S. Hamilton, J. H. Humes, J. D. Kistler, W. J. Martin, J. M. Maurer, J. H. McClelland, G. K. McGarrah, I. D. Metzgar, Geo. B. Moreland, F. S. Morris, H. S. Nicholson, W. R. Palmer, J. K. M. Perrine, S. M. Rinehart, Carl Robinsteen, Clyde W. Sample, C. P. Seip, K. S. Simpson and C. W. Truter, and four other doctors signified their desire to become members. They are as follows: E. S. Africa, C. F. Bingaman, E. C. Blackburn and G. W. Gann. Some time the latter part of January, the auxiliary expects to hold its first annual reunion and banquet, at which time we hope to have a large gathering of Hahnemann Alumni present, and also the Dean of the College, or some other member of the faculty.

George B. Moreland,  
Executive Member.

# THE HAHNEMANNIAN MONTHLY NEWS AND ADVERTISER

A Medical Newspaper.

FEBRUARY, 1912

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**Progressive Medicine.**—A quarterly digest of advances, discoveries and improvements in the medical and surgical sciences, edited by Robert Amory Hare, M. D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College, of Philadelphia, assisted by Leighton P. Appleman, M. D., Instructor in Therapeutics, Jefferson Medical College, Philadelphia. Vol. IV. December, 1911. Lea and Febiger, Philadelphia and New York, 1911.

This volume of "Progressive Medicine" is devoted to diseases of the digestive tract, liver, pancreas, kidneys, genito-urinary organs, surgery of the extremities, anesthesia, fractures and dislocations, and a practical therapeutic referendum. The section devoted to a review of therapeutic methods contains fifty pages and gives a brief summary of all the advances that have been made in medical, dietetic and hygienic methods of treatment during the past year. In addition the issue con-

tains, as usual, a comprehensive and critical summary of the recent developments in all subjects treated.

**Case Histories in Neurology.**—A selection of histories setting forth the diagnosis treatment and post-mortem findings in nervous diseases, by E. W. Taylor, A. M., M. D., instructor in neurology, Harvard Medical School; assistant physician, department of neurology, Massachusetts General Hospital; visiting neurologist, Long Island Hospital, Boston. W. M. Leonard, Publisher, 1911.

The object of this book is to set forth in practical form on the basis of the "Case System," certain fundamental facts regarding the symptomatology, diagnosis, treatment and pathological findings in the more frequent disorders of the nervous system. To accomplish this end the author has presented actual cases illustrating the different disease processes followed by such explanatory remarks as the individual case demands. The book practically serves the purpose of a clinic and will prove invaluable to the practitioner who does not have the opportunity of coming in contact with the abundant material found in the hospitals of our large cities.

**A Handbook of Medical Diagnosis**—In Four Parts, for the Use of Practitioners and Students. By J. C. Wilson, A. M., M. D. Professor of the Practice of Medicine and Clinical Medicine in the Jefferson Medical College, and Physician to its Hospital; Physician to the Pennsylvania Hospital, Physician-in-Chief to the German Hospital, Philadelphia. 481 test illustrations and 14 full page plates. Third edition. Thoroughly revised. Cloth, \$6.00 net.

This classical work which has already run through three editions in a period of three years, has proven its value as a comprehensive and practical presentation of the subject of medical diagnosis. In its 1430 pages it covers the entire field of medical diagnosis. It is divided into four parts. Part one deals with the examination of the patient, methods of taking the case and general considerations. Part two deals with the various physical and laboratory methods employed in the examination of the blood, urine, sputum, etc. In part three, the author takes up a consideration of various symptoms and signs and describes their significance, and states the diseases with which they are associated. Part four deals with the diagnosis of the various diseased states that are met with in the different organs and tissues of the body. Since the second edition of this book was issued, a number of important advances have been made which have been incorporated in the present edition. For example, the articles on epidemic poliomyelitis, pellagra and Brill's disease, have been entirely re-written. A number of diagrams and parallel column tables in the differential diagnosis of disease have also been added. Dr. Wilson is certainly to be congratulated upon having produced a work that will meet every demand of the practitioner or student of medicine in the field of medical diagnosis.

**Manual of Physiology, for Students and Practitioners.** By H. Willoughby Lyle, M. D. Former Lecturer on and Senior Demonstrator of Physiology in King's College, London. Cloth, 747 pages. 135 figures. Price.



\$4.00. Oxford University Press, American Branch, 35 West Thirty-second street, New York.

In this volume the author has endeavored to place before the student and physician as concisely as possible, the chief facts of physiology, especially as they relate to practical medicine and surgery. In reviewing the contents of this work, we have been impressed with the accuracy with which the author has presented his subject. Despite the fact that the work is not a voluminous one, it contains an enormous amount of up-to-date and authoritative information, especially the kind of information that the physician is likely to need. Diagrams of instruments and details of experiments have been largely omitted and the subjects of histology and of embryology have only been referred to in those cases where they bear directly upon the physiology of the organ under consideration. We do not hesitate to recommend this work highly to any physician desiring up-to-date and authentic information in this department of medical science.

**Lectures on Homœopathic Materia Medica.** Second edition. Cloth, \$7.00, net; half-morocco, \$8.00, net. Postage, 30 cents. Philadelphia. Boericke & Tafel. 1911.

This book in its second edition by James Tyler Kent, a well-known teacher and author is the most attractive presentation of homœopathy and materia medica that has appeared since the days of Farrington. It is written in the easy conversational style that makes it most enjoyable to the older practitioners and makes the study of materia medica easier for the student. This book would not take the place of such materia medica as Hering's or Cowperthwait's as such works are necessary to teach characterism and to study drug perspective. While Dr. Kent's style is most charming and entertaining, his lectures do not make it possible for the novice to tell the characteristic symptoms from those less important. Since the drugs are treated in such a full and complete manner that some of the symptoms dwelt upon as characteristic could hardly be considered to be quite so, for instance, in his lecture on *lilium tig* he dwells so extensively upon the intestinal symptoms of this drug that one who did not know better might consider this as important as the uterine symptoms. This is not said in a spirit of criticism as such works as Dr. Kent's are of great value to the profession, but cannot take the place of the severely mechanical arrangement presented by most of the other materia medicas.

**The Blood and its Third Anatomical Element.** Application of the Microzymian Theory of the living organization to the study of anatomical and chemical constitution of the blood and to that of the anatomical and physiological causes of the phenomena of its coagulation and of its other spontaneous changes. By A. Bechamp, formerly Professor in the Medical Faculty of Montpellier (France) corresponding member of the Academy of Medicine, etc. Translated from the French by Montague R. Levenson, M. D., of the Baltimore Medical School and M. A. and Ph. D. of the University of Gottingen. 438 pages. Cloth, \$1.50. Postage, 10 cents. Philadelphia, Pa. Boericke & Tafel. 1911.

As stated in the prospectus this book deals with the microzymian theory of disease. As yet the things that it treats of are in the land of theory and few practitioners will care to read it through. It will, no doubt, be

read with avidity by all the ologists whose ology requires the use of the microscope and a study of the chemical elements of the blood and that includes most of the ologists in the practice of medicine. The book is very radical and claims to be episodal and knocks the present microbic theory of diseases into smithereens. We would welcome it more cordially if in smashing our household idols it would do as the drug clerk does, by giving us "something just as good."

**London Practitioners' Manuals, "Minor Surgery."**—By Leonard A. Bidwell, F. R. C. S., Surgeon to the West London Hospital, Dean of the Post-Graduate College, Consulting Surgeon to the Blackheath and Charlton Hospital and to the City Dispensary, and author of "Handbook of Intestinal Surgery." Eighty-eight illustrations. London. W. B. Saunders Company, 1911. Cloth, \$5.50 net.

This little book consists of an amplification of a course of lectures delivered at the West London Post-Graduate College. The author's aim has been to give a simple and clear direction for the management of every-day surgical work. Among the subjects treated we note: Methods of sterilizing the hands, treatment of burns, ulcers, hemorrhages, shock, description of various minor operations, injection of "606," aspiration of joints, application of splints, preparation of rooms for operations, after-treatment of patients, etc.

**Collected Papers by the Staff of St. Mary's Hospital (Mayo Clinic, 1910.**  
—Collected Papers by the Staff of St. Mary's Hospital (Mayo Clinic) for 1910. Octavo of 633 pages, illustrated. Philadelphia and London. W. B. Saunders Company, 1911. Cloth, \$5.50 net

The first volume of "The Collected Papers by the Staff of St. Mary's Hospital," was received with so much favor by the profession that the publishers have decided to publish similar collections of papers once a year, or whenever it may seem desirable. The papers in the volume now before us cover a variety of conditions of interest to the physician and surgeon. There are twenty-eight papers dealing with the alimentary canal. Among these we note the following: Differential diagnosis of disease causing gastric disturbance, clinical experiments with the Cammidge reaction, pathology and clinical significance of gastric ulcer, surgical cure of cancer of the gastro-intestinal canal, the dyspeptic type of chronic appendicitis with differential diagnosis, etc. Other papers of the series deal with hernia, the genito-urinary organs, the ductless glands, head and neck, and the general surgical technique. From personal experience we can say that we have found the first volume of this series an invaluable aid in acquiring an accurate and up-to-date understanding of the conditions treated in the various papers. The second volume is fully up to the standard of the first and we can recommend it highly to every progressive physician and surgeon.

**Infections of the Hand. A Guide to the Surgical Treatment of Acute and Chronic Suppurative Processes in the Fingers, Hand and Forearm.**—By Allen B. Knavel, M. D., Assistant Professor of Surgery, Northwestern University Medical School, Chicago. Octavo, 447 pages, with 133 illustrations. Cloth, \$3.75, net. Lea & Febiger, Philadelphia and New York, 1912.

It is strange that the surgery of infections of the hand has never before been properly explained, for this member is the most exposed

portion of the human body, is the universal tool in all industries, and is indispensable for the great mass of mankind in making a living and in almost every action of daily life. Anatomically the hand is tremendously compact, particularly in its various muscles, tendons and fasciæ, and its direct connection with the lymphatics of the arm makes its infections highly dangerous. Dr. Knavel has made a special study of all these problems, and has been able to reduce the hitherto unsatisfactory surgery of the hand to comparatively simple principles and directions. He has illustrated his work with many original drawings. Such a work will be needed not only by every surgeon, but also by all general practitioners, for injuries of the hand are met everywhere, and require prompt and proper care. It is rare that any medical book can be said to render a high public service, but this is obviously true of the present work.

**Some Rough Notes on Modern Diagnostic Methods.**—This little booklet of thirty-five pages has been forwarded to the members of the medical profession with the compliments of the manufacturers of Fellows Compound of Hypo-phosphates. It presents in a condensed and comprehensive form for quick and ready reference, information regarding the newer diagnostic methods. Among the subjects treated are the examination of the feces, sputum and exudates, the Widal reaction, the Wassermann reaction, the tuberculin reaction, etc. We are strongly impressed with the value of this little work, which will give the busy practitioner in one half hour's reading as much information as he could ordinarily obtain from many hours' study of text-books and journals. A card addressed to the Fellows Company, of New York, with a request for a copy will bring the booklet free of charge to any physician.

**The Rhode Island Homœopathic Medical Society** held its sixty-second annual meeting on Friday, January 12th, at Narragansett Hotel, Providence, R. I. The following scientific program was presented: "The Surgical Treatment of Prostatic Hypertrophy," Leon T. Ashcraft, M. D., Philadelphia, Pa. Discussion opened by Dr. H. A. Whitmarsh. "Difficult Labors," George B. Earl, M. D., Boston, Mass. Discussion opened by Dr. R. S. Phillips. "Stereopticon Lecture on Dermatology," Frederick M. Dearborn, M. D., New York. Following the scientific session a banquet was served at which a number of prominent physicians and laymen were present.

**Hahnemann Medical Society of Reading.** A stated meeting of the Hahnemann Medical Society was held at the Homœopathic Hospital, Thursday evening, December 7th, at 9 P. M. The meeting was called to order by the President, Dr. Charles Haman. Members present, Drs. Charles Haman, Chester B. Gennings, William R. Haman, Theodore Pachali, S. L. Driebellis, A. S. McDowell, George R. Curry, Clifford D. Harvey and F. H. Lawrence, Secretary. The minutes of the meeting were read and approved. Dr. Chester B. Gennings, the essayist for the evening read an instructive paper on "Post Operative Treatment of Laparotomy," after which all entered into a general discussion of the subject. The President, Dr. Charles Haman, appointed Dr. Theodore



Pachali essayist for the month of March. The Society then adjourned to meet the first Thursday of February. The essayist will be Dr. S. F. Driebellis, who has for his subject "Medical Hobbies."

Frank H. Lawrence, Secretary.

**A Fine Line of Sterilized Solutions.** Hermetically sealed glass ampoules containing sterilized solutions of important drugs for hypodermic use have assumed a commanding place in medicine in a comparatively short period of time. Two or three years ago, seeing the tendency in this direction, Parke, Davis & Company brought out a modest line of something like a half-dozen formulas, notable among them being solutions of adrenalin, codrenin and cacodylate of sodium. From this small beginning the line has expanded until now the company announces a total of about twenty distinct formulas. The full list, we understand, is now appearing in display advertisements in the leading medical journals of the country. Physicians who are interested in this advance in hypodermic medication—and every physician ought to be—will do well to search out these advertisements and familiarize themselves with the comprehensive lines of solutions therein offered. Solutions provided by the glaseptic ampoule, it is obvious, have several advantages over those prepared in the ordinary manner. They are ready for immediate use, there is no necessity to wait until water can be sterilized and cooled. Accuracy of dose is ensured, each ampoule containing a definite quantity of medicine. The solutions are aseptic, they are permanent.

**Washington Letter.** The regular monthly meeting of the Washington Homœopathic Medical Society was held at the Hotel Shoreham, on Tuesday, January 2, 1912, at which the election of officers took place. Dr. Gregg C. Birdsall, President; Dr. William H. Buchanan, Vice-president; Dr. Merton E. Twogood, Corresponding Secretary; Dr. Clifton King, Recording Secretary; Drs. H. W. Hawxherst and William R. King, members of the Advisory Board. After the ballots were all in and counted, the Society indulged in some discussion upon hospital affairs which took up the time to too great an extent and prevented the holding of the scientific program, which was postponed to the next regular meeting in February. A musical and literary entertainment was held at the Arlington Hotel on Tuesday evening, January 16th, at 8.30 for the benefit of the Homœopathic Hospital Dispensary. The program included selections from scenes from Shakespeare's "Twelfth Night," and rhythmic interpretation of Strauss' "Blue Danube." Dr. William H. Heron has returned from a holiday trip to the Bermuda Islands. Dr. H. H. Hawxhurt has moved his offices to 1634 Connecticut avenue. Dr. Frank Towner has been taking care of Dr. Heron's practice during his absence from the city.

**Society Endorses Wiley.** Resolutions of congratulation to Dr. Harvey W. Wiley were duly adopted by the Medical Society of the District of Columbia at its meeting, October 11th. The resolutions set forth that the members have been deeply interested in the investigation of the work of Dr. Harvey W. Wiley in his efforts to secure the enforcement of the pure food regulations; that they heartily rejoice that Dr. Wiley has been completely exonerated from any alleged wrong-doing and that his methods and principles have been fully vindicated, and furthermore presented to the President of the United States their commendation of the justice, wisdom and impartiality displayed in his settlement of the dispute.

# FELLOWS' SYRUP of HYPOPHOSPHITES

A uniform result may always be confidently  
expected from this faithfully-prepared and  
long-tried preparation

*Reject* < Worthless Substitutes  
Preparations "Just as good"

**New Maternity.** The Elisha Francis Riggs Memorial Building of Georgetown University Hospital, especially designed for the care of maternity cases, is under roof and will be in operation in January next. The first floor of the building will provide for twenty-four colored charity patients; the second floor is designed for a similar number of white patients; the third floor will accommodate twenty patients who will pay from \$10 to \$12 per week, and the fourth floor is to be devoted entirely to private rooms. Each floor has separate delivery and recovery rooms, accommodations for nurses, diet, kitchen, etc. Another pavilion, 30 by 100 feet, will be erected on the corner of Thirty-sixth and N streets, which will be devoted entirely to the care and treatment of mental and nervous diseases. This pavilion will fill a distinct need in the care and treatment of this class of patients and will greatly enhance the facilities for clinical instruction in the University.

**Death of Surgeon-General Walter Wyman,** United States Public Health and Marine-Hospital Service, occurred in the Providence Hospital, Washington, November 21st, aged 63. He was born in St. Louis, August 17, 1848, the son of Edward Wyman, LL.D., widely-known as an educator, and Elizabeth Hadley Wyman. He graduated from the St. Louis University in 1866, then attended Amherst (Mass.) College, from which he received the degree of A. B., in 1870 and that of A. M. in 1889. His medical course was taken in St. Louis at the St. Louis Medical College, the Medical Department of Washington University, from which he was graduated in 1873. He also received the honorary degree of LL. D. from the Western University of Pennsylvania, Pittsburgh, in 1897, from the University of Maryland, Baltimore, in 1907, and from Amherst College in 1911. He entered the Marine Hospital Service as assistant surgeon, October 21, 1876; was promoted to surgeon October 1, 1877, and was made supervising surgeon-general May 27, 1891. In 1902 this service was expanded into the United States Public Health and Marine Hospital Service. During his administration as surgeon general many improvements and advances in the service have occurred. Special attention was given to the physical conditions affecting sailors in the merchant marine, for whose benefit laws were enacted. Official notice was called to the cruelties practiced on deck hands on river steamers and on crews of oyster boats. Cholera was barred from the country and many epidemics of yellow fever were successfully handled. A sanatorium for consumptive sailors was established at Fort Stanton, N. M., and the routine management of the marine hospitals was improved. Laws regulating the manufacture and sale of vaccines and serums have been enacted, and a hygienic laboratory at Washington and a leprosy station at Hawaii have been established. For the many advances made during his service as surgeon-general, Dr. Wyman is deserving of much credit.

General Wyman's society membership was extensive and included the American Medical Association, of which he was vice-president in 1905-06; the American Public Health Association, of which he was president in 1902-03; the Association of Military Surgeons of the United States, of which he was president in 1904-05; and the American National Red Cross, of which he was vice-president and acting president in 1904, and a member of the central committee and board of consultation in 1905. He was also a member of the American Academy of Medicine, American Medical Editors' Association, American Association for the



Advancement of Science, American Climatological Society and many others. He was an honorary member of the Imperial Society of Medicine of Constantinople, the president of the first and also of the second General International Sanitary Convention of American Republics and the chairman of the International Sanitary Bureau of American Republics. He was also chairman of the Committee on International Quarantine of the Pan-American Medical Congress in 1896, and of the section on Public Health of the International Congress of Arts and Sciences in 1904; president of the section on State and Municipal Control of the International Congress of Tuberculosis in 1908, and was a director of the National Association for the Study and Prevention of Tuberculosis and the National Association of Mental Hygiene.

**Physician's Offices for Rent.**—The offices of Dr. Francis E. Archibald, recently deceased, situated at 2211 North Sixteenth Street, Philadelphia, Pa., are for rent. The offices are situated in a well populated residential section of Philadelphia, convenient to business streets and street car lines. They have been used by a physician for fifteen years. Address all communications to M. D. P. Archibald, 2211 North Sixteenth Street, Philadelphia.

**Exceptional Opening in West Philadelphia.** Two physicians established in general practice twelve and fifteen years respectively, are now doing special work in centre of city. They desire physician to eventually take over all general work. Percentage plan at present. Combined practice with \$8,000 at conservative figure. Investment of \$1,000 required. Write Dr. Flanders, Care of "Hahnemannian Monthly," 1631 Arch street, Philadelphia.

**Prevalent Diseases.** Each change of season brings with it, its diseases seemingly peculiar to the time. Summer with its intestinal disorders, sunburn, insect bites, ivy poisoning, etc. Fall presents for the attention of the physician, its typhoid cases and winter and early spring, has regular quota of pneumonic, bronchial, throat and other chest conditions. At this season, when pneumonia and bronchitis demand the call of the physician, literature presenting the experience of fellow practitioners, in the successful handling of these cases, would seem most apropos. The Bloodless Phlebotomist for January reflects the experience of many physicians upon this timely subject. Dr. Charles Buck, of Cincinnati, presents his experience in handling cases of pneumonia, also relates some facts in the treatment of lumbago, which might also be considered as an affliction prominently manifesting itself at this season. "Broncho-Pneumonia" with supportive as well as local treatment in all its details, is the subject of the paper of F. A. Kautz, also of Cincinnati. Dr. E. Clinton Murray, of Houston, Texas relates his experience and treatment in a case of pneumonia in an eighteen months old baby, and Dr. J. C. Klippinger, of Independence, Kans., presents a "Different Technique in Pneumonia," which is decidedly original. In abstract his method is to apply the local dressing in a manner which gives the intercostal muscles a chance to functionate without restriction from bandages. This symposium is closed with a paper from Dr. W. A. Radue, of Union Hill, N. J., upon "Acute Pleurisy and a Successful Abortive Treatment." Besides the papers referred to, upon the subject of chest and throat diseases, much additional information is given. The

one in particular we would have you note is the "Rational Influence of Hot Applications," by that well-known therapist, Dr. Finley Ellingwood, of Chicago, Ill. A postal card addressed to the Bloodless Phlebologist, No. 57 Lighthouse street, New York, will bring you a copy of the January issue.

**Post-Graduate Courses at Hahnemann Medical College of Philadelphia.** A Post Graduate Course in Clinical Medicine for the General Practitioner, will be given at Hahnemann Hospital and College, May 20 to June 15, 1912. The course will be divided into three parts, any one of which may be taken separately. It will be entirely practical in character and is designed to meet the needs of the general practitioner who desires an opportunity to acquaint himself with the more recent methods employed in the diagnosis and treatment of disease.

#### **Course in Clinical Medicine.**

9 A. M. to 11 A. M., Drs. Golden, Yeager and Wells will be in charge of the work in the Hospital Wards and in the Clinical Laboratory. It will include the taking of case histories, the physical examination of patients, and such laboratory examinations of blood, sputum, urine, gastric contents, etc., as may be necessary to establish a full and accurate diagnosis of the case under consideration. Special attention will also be given to the study of the case from a therapeutic standpoint, and the most practical and satisfactory methods of arriving at the indicated remedy will be demonstrated.

11 A. M. to 12 M. This time will be devoted to Clinical Talks and conferences on the cases previously studied, conducted by Drs. Bartlett, Haines and Paxson. In these talks special emphasis will be laid upon the diagnostic features of the case, together with a comprehensive review of the most recent information on the subject under discussion.

#### **Physical Diagnosis Course, 1 P. M. to 3 P. M., Five Days Weekly.**

Drs. Williams and Steele.

This will be a practical course in physical examination. The physical signs of the normal chest and abdomen will first be studied. There will be personal instruction in the technique of percussion and auscultation, with a study of the mechanical causes of the various normal and abnormal sounds. All practical methods of examination will be demonstrated. After this the abundant material in the Hospital Wards and the Out-Patient Department will be drawn upon to illustrate the findings in diseased conditions of the lungs, heart and abdomen. Patients will be assigned to members of the course for diagnostic investigation, the findings carefully reviewed and analyzed by the instructor, and their clinical significance discussed in a short talk.

#### **Laboratory Course, 3 P. M. to 4 P. M., Five Days Weekly.**

Drs. Sappington and Wurtz.

This will consist of a routine drill in the various laboratory methods of diagnosis, especially those essential and practical for the General Practitioner's daily use. Theory will be followed by practice, the members of the course being allowed to work out their own cases, applying laboratory methods at the bedside.

This course fully covers urinalysis, blood counting and smears, sputum, bacteriology and general clinical microscopy. Serology (especially the Wassermann Test), and the preparation and use of vaccines will be demonstrated. In addition to the foregoing, live clinics for all the members will be given on Saturdays at 1 P. M., as follows:

May 25th, Surgical Clinic, Dr. Wm. B. Van Lennep.

June 1st, Neurological Clinic, Dr. John J. Tuller.

June 8th, Pediatric Clinic, Dr. C. S. Raue.

June 15th, Therapeutic Clinic, Dr. O. S. Haines.

Each member of the course will provide himself with a stethoscope. Microscopes and laboratory apparatus will be supplied at a small charge.

Fee, for the entire course, \$30.00. For each part, \$10.00.

Post-graduate work in any of the specialties may be arranged in conjunction with part of the practitioner's course.

The College is prepared to give regular post-graduate work in any branch at any time during the calendar year.

For further particulars address the Dean.

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# Pennsylvania State Society News

## *JOURNAL COMMITTEE*

D. P. Maddux, M. D.

Harry S. Weaver, M. D.

Ralph Bernstein, M. D.

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**Membership in the Institute.** The strength of any organization is measured by the number of members on its membership roll. Pennsylvania proudly boasts of 700 members who endorse their State Medical Society, which is at least fifty per cent. of the number of homœopaths within the State. Surely this is something to be proud of, and which at once makes Pennsylvania stand out pre-eminently and profoundly as having the best organized State medical society in the Union. This has been made possible by the assistance of active membership committees who in the past few years have proposed as many as 300 new members; last year's committee being a record-breaker in itself, having totaled for the year's work 130 new members. Two years previous to that time the membership committee, with the active co-operation of all upon it, totaled 100 new members. At this ratio of proportion Pennsylvania cannot help but continue her lead and continue her boast as the "Keystone State of Homœopathy."

It is the duty of every homœopathic physician, whether he endorses his State Medical Society or not, to endorse his national society—The American Institute of Homœopathy. While unfortunately this year there are not available funds within the Institute to carry on an active campaign within this State, nevertheless those of the 700 who do not already endorse their national society, of which there are about 500, should at once make application for membership in the same; so that Pennsylvania can extend her boast within the domains of the national society. Surely, from the latest statistics, she is not very far behind her close State neighbors, and it should be her aim within this year,



even though the Institute is unable to assist financially in an active campaign, to see to it that as many new members as possible be gotten for the Institute.

Now that the National Government has officially recognized homœopathy, surely the loyalty and devotion of every homœopath within the State of Pennsylvania should be of sufficient calibre to want to make him endorse his national society by his membership. Those desiring application blanks can have the same by applying to the President of the Institute, a fellow Pennsylvanian, Dr. Thomas H. Carmichael, No. 7127 Germantown avenue, Philadelphia, Pa., who will see that they are promptly supplied.

Since the Institute has seen fit to honor Pennsylvania by electing Dr. Carmichael as its president, and as well having further honored the State by deciding to meet within its confines during the coming year at Pittsburgh, in June, surely this should be incentive enough for the homœopathic loyalists to want to not only endorse the Institute with their membership, but their presence as well. Pennsylvania must make a formidable showing, so it is up to Pennsylvania homœopaths to do what is merely their duty.

Ralph Bernstein.

**The Homœopathic Medical Society of the County of Philadelphia,** held its regular monthly meeting on the evening of December 14, 1911, at 9 o'clock, at Hahnemann Medical College. The following scientific program was presented: "A Plea for the Surgical Treatment of Hernia," Dr. G. A. Van Lennep; "Secale Cornutum in Entero-Colitis," Dr. T. C. Imes; "Some Experiences with Arsenicum," Dr. R. E. Tomlin; "Colocynthis, an Obscure Intestinal Case," Dr. I. B. Gilbert. The meeting, being the last of the year, was unusually well attended, and the subjects were heartily discussed.

Wm. M. Sylvis, M. D., Secretary.

**The Germantown Homœopathic Medical Society** held its regular monthly meeting on Monday, December 3, 1911, at 9 P. M., at the Union League. Dr. Willard D. Bigelow addressed the Society on "Some of the Results of the Food and Drug Act." The censors reported favorably upon the name of Dr. Samuel W. Reeves, of Philadelphia, a graduate of Hahnemann Medical College, Philadelphia, class of 1909. Officers for 1912 were nominated, and six members of the entertainment board were also nominated and elected.

Landreth W. Thompson, M. D., Secretary.

**The Clinico-Pathologic Society of Philadelphia** held its regular monthly meeting at Hahnemann College on Saturday evening, December 16, 1911, at 8 o'clock. The first part of the program was occupied by the presentation of clinical cases, which was followed by the presentation of the following papers: "The Ocular Manifestations of Diabetes," F. O. Nagle, M. D., Philadelphia; "A Case of Lymphatism," R. S. Leopold, M. D., Philadelphia; "A Case of Hemorrhagic Pancreatitis with Fat Necrosis," S. W. Sappington, M. D., Philadelphia; "Double Malignancy in the Same Organ: a Note on Two Cases," J. D. Elliott, M. D., Philadelphia. Officers for the ensuing year were nominated. The meeting was well attended and hearty discussion entered into.

Benj. K. Fletcher, M. D., Secretary.

**The Philadelphia Society for Clinical Research** held its regular monthly meeting on the evening of December 20, 1911, being entertained by Dr. Ralph Bernstein, No. 37 South Nineteenth street, Philadelphia. The subject of Dr. Bernstein's paper was "Recent Advances in the Successful Treatment of Epithelioma." The meeting was well attended.

Walter J. Snyder, M. D., Secretary.

**The Women's Homœopathic Medical Association of Pittsburgh** held its regular monthly meeting at the office of Dr. Anna D. Varner, No. 616 Wood street, Wilkesburg, Pa., on Thursday, January 4, 1912, at 8 P. M. Mrs. Lizzie Foster, of Waterville, Me., who has just returned from an extended tour of the Orient, visiting mission stations in India, Burmah, China and Japan, was the guest of honor, and her address was not only exceedingly instructive but much enjoyed by the large number of members in attendance.

Mary E. Coffin, M. D., Secretary.

**The Lehigh Valley Homœopathic Medical Society** held its regular meeting at the Hotel Karlton, Easton, Pa., on January 4, 1912. Dr. O. S. Haines, Professor of Materia Medica of Hahnemann Medical College of Philadelphia, was present and delivered one of his interesting and instructive papers, his subject being, "Chronic Myocarditis." Two other interesting papers were presented as follows, "Valvular Heart Disease," by Dr. E. D. Doolittle; "The Nervous and Hemorrhagic Types of Typhoid Fever," by Dr. A. L. Kistler. Dinner was served at 1 P. M.

S. C. Swartz, M. D., Secretary.

**The Homœopathic Medical Society of Chester, Delaware and Montgomery Counties** held its holiday meeting at the Colonnade Hotel, Philadelphia, Pa., on Tuesday, December 12, 1911, at 1 P. M. Dr. J. W. Mullin, of Wilmington, Del., read a short paper on "That Sacred Prescription." President J. W. Pratt, M. D., of Coatesville, Pa., opened the discussion and delivered his inaugural address. H. P. Leopold, M. D., of Philadelphia, presented a paper on "Post Operative Treatment in Abdominal Cases;" the discussion being opened by Dr. D. P. Maddux, Chester, Pa. A special luncheon with music was served at 1.30 sharp, at which time the new president of the State Medical Society, G. J. Palen, M. D., and William W. Speakman, M. D., both of Philadelphia, made brief remarks. This meeting was unusually well attended and voted quite a success by all who had the pleasure of being present.

Isaac Crowther, M. D., Secretary.

**The Regular Monthly Meeting of the Homœopathic Medical Society of the 23rd Ward, Philadelphia**, was held on Wednesday, December 20th, 1911, at the office of Dr. A. D. Krewson, 4613 Paul street, Frankford, Philadelphia, Pa. The subject which Dr. Krewson presented for discussion was a paper on "Biliary Calculi." The meeting was well attended and hearty discussion entered into.

J. D. Boileau, M. D., Secretary.

**The Delaware County Homœopathic Medical Society** held its January meeting on the 11th inst., in the Y. M. C. A. Building, Chester, Pa., at 3.30 P. M. The scientific program was as follows: "Psychotherapy from the Standpoint of the Medical Internist," G. Harlan Wells, M. D.,

Philadelphia; "Leprosy," J. Percy Craig, Chester, Pa. These papers were ably presented and heartily discussed. Dinner was served at 5 o'clock. The meeting was well attended.

G. C. Webster, M. D., Secretary.

The Homœopathic Medical Society of the County of Philadelphia, held its regular monthly meeting at Hahnemann Medical College, Thursday evening, January 11, 1912. The scientific portion of the program consisted of the following papers: "Diagnosis and Treatment of Chronic Bronchitis," Dr. W. R. Williams; "Clinical Report of a Case where Lachesis was Used," Dr. George MacKenzie; "Report of Two Cases of Skin Lesions Cured by Arsenicum," Dr. Wm. H. Yeager; "A Few Approved Characteristics in Materia Medica," Dr. Augustus Korndorfer.

Wm. M. Sylvis, Secretary.

**Notice to Secretaries.** Personal items and reports on medical society meetings are earnestly solicited for use in the various homœopathic medical journals throughout the United States. Secretaries and those having news and personal items are cordially invited to forward the same to Ralph Bernstein, M. D., No. 37 South Nineteenth street, Philadelphia, Pa., so that they can be arranged for publication.

The Maryland Homœopathic Hospital, of Baltimore, Md. The officials of this institution are desirous of securing a resident physician to fill an unexpired term until June 1st, 1912, and should be pleased to hear from any physician caring to apply for the position.

**A Distinctive Piece of Literature.**—"Here is something different." This is apt to be the first thought of the physician upon breaking the wrapper of Parke, Davis & Company's new brochure on bacterial vaccines and tuberculins. And the external appearance of the book is in no wise misleading. The "difference" applies to the printed page as well as to the handsome cover in artistically blended browns and gold. The brochure contains forty-eight pages in addition to the cover and thirteen full page engravings in colors. The work is divided into three parts or sections. Some of the subjects considered in the first section are: "What is the Difference Between Bacterial Vaccines (Bacterins), Serums and Toxins?" "How are Bacterial Vaccines Prepared?" "Therapeutic Action of Bacterial Vaccines;" "When Should Serums be Used, and When Bacterial Vaccines?" The second section treats of the origin and nature of the bacterins, the relative merits of "stock" and "autogenous" vaccines, the opsonic index and the best method of using the bacterins, together with a description of each vaccine, including references to preparation, therapeutics and dose. The third section is devoted to a consideration of the tuberculins, with dilution and dose tables, descriptions and illustrations of the various diagnostic tests, etc. Briefly stated, the booklet is a concise review of the essential facts relating to bacterial-vaccine therapy, containing precisely what the seeker after this kind of information wants. It is not padded with clinical reports—in fact, it contains none. We understand that Parke, Davis & Company will be pleased to send a copy of this unique and valuable brochure to any physician requesting it. Address them at their home offices, Detroit, Mich, specifying the "new booklet on bacterial vaccines," and mention this journal.



# THE HAHNEMANNIAN MONTHLY NEWS AND ADVERTISER

A Medical Newspaper.

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MARCH, 1912

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**A Handbook of Practical Treatment.**—By many writers. Edited by John H. Musser, M. D., L.L. D., Professor of Clinical Medicine in the University of Pennsylvania, and A. O. J. Kelly, A. M., M. D. Volume III. Philadelphia and London, W. B. Saunders Company, 1912.

The third and last volume of this work deals with many diseases that are of especial interest to the general medical practitioner. The first section deals with constitutional diseases, among the more important of which are diabetes mellitus, gout, scurvy and the uric acid diathesis.

The second deals with diseases of the respiratory tract, including diseases of the nose and throat, asthma and hay fever, emphysema and congestion of the lungs, diseases of the pleura, etc.

Under Diseases of the Digestive System we note an important section on the Hygiene of the Mouth and Teeth, by M. H. Cryer; Surgery of the Aesophagus, by Charles H. Mayo; Diseases of the Stomach, by Bertram W. Sippy; Surgery of the Stomach and Duodenum Constipation, by John H. Musser; Disease of the Pancreas, by James M. Anders; Peritonitis, by John J. Jopson. The remaining chapters deal with diseases of the urinary system, nervous system and muscles and of the mind.

The list of contributors to this volume include many of the most eminent authorities in the United States and England, giving to the reader the advantage of the most recent information obtainable regarding the treatment of the disease under consideration.

While drug therapy has been presented in full the authors have by no means limited their discussions to this phase of therapeutics; but all other means of treating disease has been fully described.

The complete work in three volumes represents probably the most comprehensive treatise on practical treatment ever undertaken in America.

**Diseases of the Ear, Nose and Throat.**—For the family physician and the under-graduate medical student, by Henry Ottridge Reik, M. D., associate in Ophthalmology and Otology in the Johns Hopkins University, assisted by A. J. Neilson Reik, M. D., with eighty-one illustrations in the text and two colored inserts. New York and London, D. Appleton and Company, 1911.

The aim of this manual is to present to the family physician and to the under-graduate medical student in the simplest possible manner all that he needs to know regarding the diseases of the ear, nose and throat. The first section of the work is devoted to diseases of the ear and the symptomatology of oral disease. The section dealing with diseases of the nose and throat begins with a thorough description of the anatomy and physiology of the upper respiratory tract, followed by chapters of methods of examination, symptomatology of nose and throat diseases, local treatment of nose and throat by means of powders, vapors, sprays, etc. The last chapter deals with general diseases in which affections of the nose and throat may occur. The work is not an elaborate one, containing less than four hundred pages. It is the merit, however, of presenting the subjects in a practical manner, and intricate details such as would be of value only to the specialist, are omitted. The author has admirably succeeded in presenting the subject in such a way as will appeal to the general medical practitioner.

**London Practitioner's Manuals, Anaesthesia and Analgesia.**—Anaesthesia and Analgesia by J. D. Mortimer, M. B., (London) F. R. C. S. (England). London, University of London Press. Published for the University of London Press, Ltd., by Hodder & Stoughton and Henry Frowde.

This little volume contains a practical presentation of the subject of anaesthesia. A list of some chapters will give a general idea of its scope and character, for example: Chapter I deals with the preparation and examining of the patient and the methods of administering an anaesthetic. Other chapters deal with Nitrous-oxide, Ethylchloride, Ether, Chloroform etc. The Difficulties and Dangers of Anaesthesia, Emergencies and

How to Meet Them; Special Analgesia and Local Analgesia. The Theoretical Side of Anaesthesia has been entirely omitted and the greatest emphasis has been placed upon such subjects as The Preparation and After-Treatment of the Patient; The Relative Advantages and Disadvantages of Certain Anaesthetics and the Difficulties Peculiar to Certain Operations. Important facts have been emphasized throughout the book by being printed in large type.

**Serum Diagnosis of Syphilis and the Butyric Acid Test for Syphilis.**—By Hideyo Noguchi, M. D., M. Sc., Associate member of the Rockefeller Institute for Medical Research, New York. Fourteen illustrations. Second edition. Philadelphia and London, J. B. Lippincott Company. Price, \$2.50.

The object of this book is just to give a brief account of the principles of Serum Hemolysis and of the behavior of the combinations of antigens and antibodies toward hemolysis, and secondly, to give in detail the technique of the Wassermann and Noguchi tests. The author has endeavored to treat this book in such a manner as to make it useful to practicing physicians and students and at the same time to render it useful to laboratory workers.

In the present edition a great deal of new information has been introduced. The methods of preparing tests have been very much simplified.

The chapter dealing with the clinical value of the Wassermann reaction is an extremely interesting one, and in it are incorporated the views of clinicians from all parts of the world who have given special study to this subject.

The author's Butyric Acid Test is explained in detail and its advantages in certain conditions pointed out.

A valuable addition to the work is a complete summary of all the literature on the subject to date.

Dr. Noguchi's book is by far the most complete and authoritative work on the subject of Serum Diagnosis of Syphilis published in the English language.

**Case Histories in Medicine.**—Illustrating the Diagnosis, Prognosis and Treatment of Diseases by Richard C. Cabot, M. D., Assistant Professor of Clinical Medicine, Harvard Medical School. Second Edition, revised and enlarged. Boston, W. M. Leonard, Publisher, 1911.

The immediate success that attended the first edition of this work has necessitated a second edition. In publishing the second edition the author has done so with a view of adapting it to the needs of the medical practitioner, and greater details regarding the prognosis and treatment have been given. The interest in Dr. Cabot's book lies in the fact that he presents puzzles similar to those which confront us at the bedside, and then at the end of each case he states briefly his conclusion and the data which enabled him to arrive at it. It is a work in which any physician will find both instructive and entertaining reading.

**Surgical Clinics of John B. Murphy, M. D. Vol. I; No. 1.**—Octavo of 133 pages, illustrated. Philadelphia and London, W. B. Saunders Company, 1912. Published bi-monthly. Price per year, paper, \$8; cloth, \$12.



# The Hahnemannian Monthly

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OFFICIAL JOURNAL *of the*  
HOMOEOPATHIC STATE  
MEDICAL SOCIETY OF  
PENNSYLVANIA : : : :

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This, the first number of the "Surgical Clinics of John B. Murphy, M. D.," represents a new departure in medical publishing. It is a departure, however, that must appeal at once to the medical man, because it is extremely practical clinical teaching. These are not students' clinics, but Dr. Murphy's famous clinical talks at Mercy Hospital, Chicago, for physicians only. A point we want to mention is that these "Clinics" are published just as delivered by Dr. Murphy, being reported verbatim by an expert medical stenographer. In this way they retain all that individual force and charm so characteristic of the clinical teaching of this distinguished surgeon. These "Clinics" are being issued in serial form, one number every other month (six numbers a year). Each number is to contain about 130 octavo pages, illustrated. The price (sold only by the year) has been fixed at \$8.00 in paper binding, \$12.00 in cloth.

**Location Wanted.**—Graduate "Old Hahnemann," Philadelphia; fourteen years' successful professional experience (some surgery), desiring larger field, seeks bona-fide location, industrial town, 5,000 or more with good schools, churches (Protestant); suburban railroad facilities, New Jersey or Pennsylvania only, where fees and collections are good; county seat not objectionable; established practice 13,000 or more with proper opportunities for specializing in chronic diseases, of physician removing or retiring preferred; would purchase introduction on reasonable terms and rent old stand if possible. No real estate bought; no agents. Give full particulars first letter. Address "Location," care of "Hahnemannian Monthly," 1631 Arch street, Philadelphia, Pa.

**The Homœopathic Medical Society of the State of New York**, held its Sixtieth Annual Meeting in Albany on February 13 and 14, 1912. A large number of important and interesting scientific papers were read. On Tuesday evening a banquet was held at the Hotel Ten Eyck, Dr. John W. Lee Seur, of Batavia, acting as toastmaster.

**The West Jersey Homœopathic Medical Society** held its winter meeting at the West Jersey Homœopathic Hospital, Camden, N. J., Wednesday, February 21, 1912. Dr. William T. Hilliard, of Salem, presented a report on "Some Obstetrical Cases." Dr. George D. Woodward, of Camden, sent a report on "Some Surgical Cases." Dr. T. H. Carmichael, President of the American Institute of Homeopathy; Dr. Gilbert J. Palen, President of the Homœopathic Medical Society of the State of Pennsylvania and Dr. Atkinson, President of the New Jersey Homœopathic Medical Society, were present and gave short talks on the present status of homœopathy. The meeting was a very successful one and aroused considerable enthusiasm among the members present.

**The National Confederation of the State Medical Examining and Licensing Boards** held its twenty-second annual convention at the Congress Hotel, Chicago, February 29, 1912. The following program was presented: "What a National Federation of State Boards can do," Dr. Albert B. Brown, State Board of Louisiana; "What Should be the Requirements for Membership in a National Federation of State Boards?" Prof. John Milton Dodson, Rush Medical College; "Best Methods of Conducting State Licensing Examination," Dr. George H. Matson, State Board of Ohio; "Medical School Equipment and State Board License Examination," Prof. Frank Fairchild Westbrook, University of Minne-

sota. The officers of the Confederation are: President, Charles A. Tuttle, M. D., 196 York Street, New Haven, Conn.; Secretary-Treasurer, Geo. H. Matson, M. D., State House, Columbus, Ohio.

**The Pittsburgh Alumni Association Banquet.** The First Annual Banquet of the Western Pennsylvania Auxiliary Association of the Hahnemann Medical College of Philadelphia, was held at the Hotel Schenley, Pittsburgh, July 19, 1912. Dr. William B. Van Lennep, Dean of the College, was present and responded to the toast, "Old Hahnemann and New Hahnemann." Dr. Van Lennep's address was listened to with much interest. Great enthusiasm was aroused among the Alumni present by Dr. Van Lennep's story of how the methods of instruction at Old Hahnemann had been improved and added to until the College is now among the foremost of the medical schools of the United States. The toastmaster, Dr. S. M. Rinehart, '91, was introduced by the President of the Association, Dr. W. F. Edmundson, '71. Other toasts responded to were: "Undergraduate Days," by Dr. W. J. Martin, '99; "Breaking into Practice," by Dr. R. B. Armor, '98, and "The Men of Auld Lang Syne," by Dr. J. H. McClelland, '67. Remarks were also made by Dr. Z. T. Miller, Dr. R. S. Marshall, Dr. Wm. H. Cooper, Dr. C. C. Rinehart and Dr. E. P. Clark. There were sixty-two Hahnemann men present at the banquet, and a most enjoyable time was had by all. The following afternoon a luncheon was given at the Pittsburgh Athletic Association to Dr. Van Lennep by Dr. E. R. Gregg, at which were present not only Alumni of Hahnemann, but also graduates of other Homœopathic Colleges.

George B. Moreland, M. D.

Experience is spoken of by Pliny the Younger as "that excellent Master," and what was found to be true in a bygone age is just as true in this busy twentieth century. By experience, we gain knowledge; in medicine this is specially so, for the busy practitioner relies very largely on those methods which his own experience or the experience and recommendation of those whose opinions are worth while, tells him are best.

The test of time and experience has placed Benger's Food in the front rank of proprietary foods, as that conservative paper, the British Medical Journal writes, "Benger's Food has by its excellence established a reputation of its own," and that reputation is, that "it is retained when all other foods are rejected."

For the aged, or those with weakened digestion, Bengerized Milk stands alone. A cupful at mid-day or given the last thing at bedtime is acceptable, and gives rest to the digestive organs, and supplies all the nourishment that is needed.

During convalescence from severe illnesses, Benger's should be your "sheet anchor;" it will bridge the time between illness and health better than anything else, for it is the only food that can be regulated to suit physiological conditions, and can be prescribed with the accuracy of a tincture. Cauteley considers it to be the most valuable proprietary food on the market.

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dextrose. Henry Ashby, the recognized authority on pediatrics, gave as his opinion, that it was exactly in the first six months of life that he found Benger's the most useful.

Your experience with Benger's Food will tell you it cannot be omitted from your diet list, for whenever a milk diet is indicated from infancy to old age, there is a case for Benger's Food.

**Homœopathy's Largest Hospital.** The Metropolitan Hospital, on Blackwell's Island, New York, now enjoys the one advantage it has hitherto lacked to make its service of the greatest value. A Reception Hospital with a motor ambulance, which in six months answered 1908 calls, brings every variety of acute and surgical case to the wards. No hospital can now offer a more attractive service for internes. Its eighteen months' course is divided so that each man serves in each division in rotation. Last year the 11,138 patients were divided as follows: Surgical, 1802; medical, 2803; genito-urinary, 604; mental and nervous, 291; children, 376; eye and ear, 196; nose and throat, 57; obstetrical, 218; gynecological, 104; tubercular, 4687. Ten hundred and twenty surgical operations were performed. A hint of the pathological treasures that abound is given by the number of autopsies, 194, performed in the year. This hospital, maintained by the Department of Charities of New York, has recently opened several new buildings. The new staff house resembles a well appointed club. The pathological building is perfect in arrangement for the utilization of the vast supply of morbid material. The two new pavilions for tuberculosis are equal in design and equipment to any yet built. Service by internes in the tuberculosis division is salaried.

**Married.** Mrs. William Fulton Ustick announces the marriage of her daughter, Emily Fairfield Darling, to Dr. Edwin Hicks Van Deusen, Thursday, January the 18, 1912, Philadelphia, Pa.

**Personals.** Edward M. Gramm, M. D., announces the removal of his offices to 518 Perry Building, southeast corner Sixteenth and Chestnut streets, Philadelphia, Pa.

Dr. H. S. Weaver, of Philadelphia, Pa., attended the recent meeting of the Mercer County Homœopathic Medical Society, held at Trenton, N. J., and presented a paper on "Acute Otitis Mediae."

Dr. Frank J. Slough, of Allentown, Pa., was recently appointed a member of the Board of Trustees of the new Rittersville Homœopathic Hospital for the Insane, which is now practically completed and which will be opened in the spring. Dr. Slough, who was born in 1842, was the first Lehigh County graduate of Hahnemann College, Philadelphia, and will this year celebrate his fiftieth anniversary of his becoming a practitioner. Dr. Slough, who has served as Health Officer of Allentown, County Poor Physician and a Pension Examiner, is the Nestor of the homœopaths of Lehigh Valley. He was long an advocate of a homœopathic insane asylum, believing his school peculiarly fitted for the treatment of certain mental diseases, and it is regarded as most appropriate that he was recognized.

**Obituaries.** Dr. Edward F. Fornias, a widely-known homœopathic physician of Philadelphia, Pa., died from heart failure at his home, 2435 North Eighth street, on January 22, 1912. Dr. Fornias was sixty-nine years old, and was a graduate of Hahnemann College, Philadelphia, Pa.,

in 1888. He was born in Havana, but came to Philadelphia when a boy. For a time he represented the Government of Uruguay, and was acting vice-consul for Spain.

Dr. Perry Hall Dudley, son of the late Dr. Pemberton Dudley, one time dean of Hahnemann Medical College of Philadelphia, died on January 15th, after a long illness. Dr. Dudley was graduated from Hahnemann College in 1892, and up until four years ago was connected with the Hahnemann, Children's and West Philadelphia Homœopathic Hospitals. After the death of his father he severed his connections with these institutions and entered private practice.

Dr. James Samuel Hickey, philanthropist and physician, who had been ill at his home, 1839 North Eleventh street, Philadelphia, Pa., since October last, died on January 26, 1912, from inflammation of the heart. Dr. Hickey, who was fifty-six years old, was demonstrator of anatomy at Hahnemann College, and widely known in his profession. He was born in Cincinnati, November 7, 1855, and during his early school days was a classmate of President Taft.

Dr. Gustavus Adolph Mueller, a prominent homœopathic practitioner of Pittsburgh, died on February 8th, from typhoid fever. He had been ill almost one month. Dr. Mueller was born in Crestline, Ohio, a son of August Mueller, but came to this city when a boy. He attended the Sharpsburg Academy and later the University of Michigan. In 1885 after graduating from the Hahnemann Medical College at Chicago he began practice as a physician in old Allegheny. A short time later he was made city physician of Allegheny and remained in that position until 1894. At that time he went abroad and took up post-graduate work. He studied the diseases of the throat and nose at Munich, Vienna, Paris, London and Berlin. Returning to Pittsburgh he began practice on Penn avenue as a specialist.

Dr. Mueller was a conspicuous figure in the management of the Homœopathic Hospital. He was a member of the executive committee, the board of trustees of the hospital and of the medical board of his department. He had been for four terms a member of the State Board of Medical Examiners and recently was appointed to a fifth term by Governor John K. Tener. He was a member of the American Institute of Homœopathy, the State Homœopathic Society of Pennsylvania and of the Homœopathic Medical Society of Allegheny County. He had been a former president of the latter society.

He was also a member of the faculty of the Pittsburgh Training School for Nurses and a member of the Laryngological Society, the East End Doctors' Club, the University and Duquesne Clubs of Pittsburgh, the Oakmont Country Club, the Sportsmen's Association of Cheat Mountain and the Alumni Association of Hahnemann College.

He was also a Mason and had filled all of the offices in the local lodge of Odd Fellows and was a representative of the grand lodge. He was also medical director of the Odd Fellows Endowment Association.

Dr. Mueller was one of the incorporators of the Bank of Secured Savings of Allegheny. In 1891 he married Miss Grace Miller of the North Side, who died in 1896. In 1900 he married Miss Nell A. Anderson, of Steubenville, Ohio. His widow, two sons, Gustave A., Jr., and Robert, and five sisters, Mrs. Annie Mueller and Miss Clara Mueller of the North Side, Mrs. Moses Calhoun of Monongahela, Mrs. N. L. Becker and Mrs. Emma Des Jardiens of Chicago, survive.

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# Pennsylvania State Society News

## JOURNAL COMMITTEE

D. P. Maddux, M. D.

Harry S. Weaver, M. D.

Ralph Bernstein, M. D.

**New Members for the Institute.** Pennsylvania always finds a way—a way to do things. Pennsylvania never fails in her duty; she must not fail now. Her present paramount duty is to produce new members for the American Institute of Homœopathy. It had been stated previously that there was little money in the Institute to devote to an active campaign for new members in Pennsylvania. Since that time, however, Pennsylvania has found a way; they are going to have an active membership committee which will put forth every possible effort to make a formidable showing in new members for the Institute by the June meeting.

The State Medical Society has seen fit to appoint the undersigned as chairman of the Institute Membership Committee for the State of Pennsylvania, which appointment has been endorsed by the Field Secretary, Dr. H. R. Arndt. Dr. Gilbert J. Palen, President of the State Medical Society, is actively at work in appointing a committee composed of representatives of all the Homœopathic County Medical Societies throughout the State of Pennsylvania, and surely, with their active co-operation and support, results should be produced.

While perhaps Pennsylvania has but two hundred and sixty-three members in the Institute, this may be accounted for because of the fact that at no time has a thorough and systematic canvass been made for new members for the Institute from Pennsylvania. This Committee proposes such a campaign. You will hear from them shortly, and you will receive membership blanks from them; and it is your duty as a Pennsylvania homœopath, if you are not already a member of the Institute, to become one; and if you are a member, then it is just as much your duty to see that someone else becomes a member. There is no reason why the seven hundred homœopaths who endorse their State Medical Society should not endorse their National Society—The Institute; and if it is because their membership has never been solicited, surely it will be solicited now.

The Institute this year meets in our own State, the President of the Institute this year is from our own State, and surely every homœopath of our State of Pennsylvania should make good, showing his loyalty and devotion to the cause of homœopathy by joining the Institute. Your Committee will do its work; the rest of it is up to you—so let it be.

Ralph Bernstein, M. D.

**Bureau of Medical Education and Licensure.** The new Bureau of Medical Education and Licensure is now an accomplished fact in this State, and while the law contains some things that are impractical of literal execution, it at the same time embodies certain other features that will render possible the maintenance of a higher standard of medical training in this State, and the creation of reciprocal medical relations with other States.

The Bureau has started with the dominating thought of rigid impartiality: it proposes to have the papers of all candidates only identified by an officially conferred member, and they will be marked and rated without the members of the Bureau having the slightest indication of the personality of the individual whose papers they are marking: and except in papers upon *Materia Medica* and Therapeutics, there will be no method of determining to which "school" or practice the candidate belongs.

It has been found impractical to hold the examinations in the several institutions in which the candidates are students, and one or two central halls will be selected.

A careful study of the curriculum of our own college confirms the opinion that it has nothing to fear from the proposed enactments of the Bureau, and it is gratifying to know how this same opinion is shared and expressed by some other members of the Bureau, who are associated with other medical institutions.

D. P. M.

The Homœopathic Medical Society of the County of Philadelphia held its regular monthly meeting at Hahnemann Medical College, Philadelphia, Pa., on Thursday evening, January 11, 1912. The scientific program of the evening consisted of the following papers: "Diagnosis and Treatment of Chronic Bronchitis," Dr. W. R. Williams; "Clinical Report of a Case where Lachesis was Used," Dr. George MacKenzie; "Report of Two Cases of Skin Lesions Cured by Arsenicum," Dr. Wm. H. Yeager; "A Few Approved Characteristics in *Materia Medica*," Dr. Augustus Korndoerfer. The papers were ably presented and heartily discussed by the large number of members in attendance, indicating an interest which it is hoped and believed will continue throughout the year.

Wm. M. Sylvis, M. D., Secretary.

The Homœopathic Medical Society of the County of Philadelphia held its February meeting on Thursday evening, 8th ult., at Hahnemann Medical College, Philadelphia, Pa., at 9 o'clock. The scientific program presented was as follows: "The Applicability of the Homœopathic Remedy in Gynecological and Obstetrical Cases," Dr. Augustus Korndoerfer, Jr.; "Spongia in a Case of Aneurism," Dr. Ellen Woodward Howell; "The Medical Treatment of Uterine Hemorrhage," Dr. N. F. Lane. The meeting was well attended and the papers thoroughly and heartily discussed.

Wm. M. Sylvis, M. D., Secretary

The Germantown Homœopathic Medical Society held its regular monthly meeting at the Hotel Walton, Philadelphia, Pa., on Monday evening, January 15, 1912, at 9 o'clock. This was the occasion of the annual election of officers, which resulted as follows: President, Dr. G. J. Palen; Vice-President, Dr. F. L. Abbott; Recording Secretary, Dr. W. H. A. Fritz; Corresponding Secretary, Dr. L. W. Thompson; Treasurer, Dr. I. B. Gilbert; Judiciary Committee, Drs. J. D. Boileau, W. H. Senderling, B. M. E. Peters, T. J. Gramm, W. Rile, C. W. Gessler, J. W. Thatcher, C. M. Brooks, P. H. Ealer and Warren Mercer; Censors, Drs. N. F. Lane, E. F. Humphreys and L. W. Reading.

Landreth W. Thompson, M. D., Secretary.

The Clinico-Pathologic Society of Philadelphia held its regular monthly meeting at Hahnemann Medical College on Saturday evening, January 20, 1912, at 8.30 o'clock. The program was as follows: Clinical Cases, thirty minutes. Papers: "Oesophageal Stricture—Presentation of a Case" (10 minutes), Dr. F. W. Smith; "Treatment—Stricture of Male Urethra" (10 minutes), Dr. Wm. C. Hunsicker; "Report of a Case of Ruptured Uterus" (10 minutes), Dr. J. E. James. Officers for the ensuing year were elected at this meeting, which was well attended.

Benj. K. Fletcher, M. D., Secretary.

The Philadelphia Society for Clinical Research held its regular monthly meeting at the office of Dr. M. W. Sloan, No. 4825 Baltimore avenue, Philadelphia, Pa., on January 17, 1912, at 9 P. M. The paper presented for discussion by Dr. Sloan was entitled "The Iodides." Dr. F. W. Emrey, of Philadelphia, also presented an interesting paper. The meeting was followed by a collation, Dr. Sloan acting as host.

Walter J. Snyder, M. D., Secretary.

The Homœopathic Medical Society of the Twenty-Third Ward of Philadelphia was entertained by Dr. Ralph Bernstein on Wednesday, January 17, 1912, at the Colonnade Hotel, Fifteenth and Chestnut streets, Philadelphia, Pa., who held a stereoscopic skin clinic in which he showed numerous skin diseases, and as well delivered an address on "Office Routine in the Successful Treatment of some of the More Common Skin Diseases." The meeting was well attended.

John D. Boileau, M. D., Secretary.

The Women's Homœopathic Medical Club of Philadelphia, met on Tuesday evening, February 6, 1912, at the office of Dr. Hess, 1911 Mt. Vernon street, Philadelphia, Pa., the guest of honor being Dr. Hannah B. Mulford, who gave an interesting talk on her experiences in India. The meeting was well attended and enjoyed by all present.

Dr. V. Reel, M. D., Secretary.

The Women's Homœopathic Medical Association of Pittsburgh, held its regular meeting at the office of Dr. Ella D. Goff, Library Place, Allegheny, Pa., on February 1, 1912, at 8 P. M. The subject for discussion was a paper by Dr. Anna D. Varner on "Enuresis."

Mary D. Coffin, M. D., Secretary.

The West Branch Homœopathic Medical Society, held its regular monthly meeting at the office of Dr. W. H. Follmer, Williamsport, Pa., on February 1st, at 3.30 P. M. The guest of honor was Dr. Gilbert J. Palen, of Philadelphia. President of the Homœopathic Medical Society of the State of Pennsylvania, who addressed the Society on "Aureal Diagnosis." In the evening a banquet was held at the Williamsport Country Club. Dr. Follmer spoke on "Our Society," and Dr. Palen talked on matters pertaining to the State Society. The meeting was a very enthusiastic one.

The Berks County Homœopathic Medical Society, held its regular meeting at Reading, Pa., on January 2, 1912. A very interesting paper was presented by Dr. H. P. Leopold, of Philadelphia, on "The After Treatment of Surgical Cases," which created great discussion. Dr. G. J. Palen, President of the Homœopathic State Medical Society, who was also present, addressed the Society on State Society matters. There was a large attendance.



# THE HAHNEMANNIAN MONTHLY NEWS AND ADVERTISER

A Medical Newspaper.

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APRIL, 1912

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**The Surgery of Oral Diseases and Malformations. Their Diagnosis and Treatment.** By George V. I. Brown, D. D. S., M. D., Oral Surgeon to St. Mary's Hospital and to the Children's Free Hospital, Milwaukee; Professor of Oral Surgery, Southern Dental College, Atlanta, Ga. Octavo, 740 pages, with 359 engravings and 21 plates. Cloth, \$6.00, net. Lea & Febiger, Publishers, Philadelphia and New York, 1912.

The region embraced in the title of this work is the scene of many diverse and important operations, such as those for hare-lip, cleft-palate,

and the agonizing facial neuralgias. As the roof of the mouth is the floor of the nose, deformities of the upper air passages can often be removed by a very simple widening of the upper jaw. The author has displayed great ingenuity and resourcefulness in devising new or improved operations, and these are given in detail with liberal illustrations of their successive steps. Dr. Brown also appreciates the importance of facial appearance, and has shaped his operations to accomplish aesthetic as well as practical results. His serial pictures demonstrate a great advance in this particular over what was formerly thought to suffice. Most surgeons have operations in this region to perform, and to them, as well as to dentists, and to students of medicine and dentistry, this work can be recommended as presenting the whole subject in its latest form.

**A Manual of Surgical Treatment.** By Sir W. Watson Cheyne, Bart., C. B., D. Sc., LL. D., F. R. C. S., F. R. S., Hon. Surgeon in Ordinary to H. M. the King; Senior Surgeon to King's College Hospital, and F. F. Burghard, M. S. (Lond.), F. R. C. S., Surgeon to King's College Hospital, and Senior Surgeon to The Children's Hospital, Paddington Green, London. New (second) edition. Thoroughly revised and largely rewritten. In five volumes, containing about 3,000 pages and illustrated with about 900 engravings. Price, cloth, \$6.00, net, per volume. Lea & Febiger, Publishers, Philadelphia and New York, 1912.

This work will enrich every surgeon's library and increase his efficiency by supplying him with far fuller details of operations than is possible in general books or systems of surgery. The time and attention of readers are spared by the fact that the authors have presented only the procedures that in their vast experience have proved best, and they have thus been able to cover the whole field of surgical treatment in full detail, including the steps of operations. In writing these volumes the authors have endeavored to put themselves in the place of their readers, choosing the operation best suited to each case, and then presenting everything a surgeon might need to know, including the after-treatment. Their work was warmly appreciated in its original issue, and this new edition, thoroughly revised in text, and with no less than 900 engravings, will receive an equally wide welcome.

**Recent Methods in the Diagnosis and Treatment of Syphilis.** (The Wassermann Reaction and Ehrlich's Salvarsan, "606"). By C. H. Brown-ing, M. D., Lecturer on Bacteriology in the University of Glasgow, and Ivy McKenzie, M. D., Director, Western Asylums' Research Institute, Glasgow. Octavo, 303 pages. Cloth, \$2.50 net. Lea & Febiger, Publishers, Philadelphia and New York, 1912.

In this age of research, one discovery treads so rapidly on the heels of another that their wonder and significance are apt to be overlooked. Ehrlich's final success after scientifically testing 606 chemical compounds is amazing in the vista it opens of the conquest of the most widespread and important of all human diseases. Scarcely less remarkable is the timeliness of the discovery of Wassermann's unerring test for the disease, which detects it even before the stage of visible lesions has been reached. These two epoch-making discoveries complete each other by enabling the physician to prove the presence or absence of syphilis by Wassermann's test, to treat it radically, if present, with Ehrlich's Salvarsan, and afterwards to demonstrate absolutely when it has been eradi-

cated by reapplying the Wassermann test. In this authoritative work readers will find a full explanation of the theory and principles of Ehrlich's and Wassermann's methods, their application, and a discussion of Drs. Browning and McKenzie's cases, which are ample to give the stamp of experience to their writings. The widespread interest in the subject and in the book is shown by the fact that about half the edition was sold within a few days after publication.

**Microscopy, Bacteriology and Human Parasitology.** By P. E. Archinard, A. M., M. D., Bacteriologist, Louisiana State Board of Health and City Board of Health, New Orleans. New (second) edition, thoroughly revised. 12mo, 267 pages, with 100 engravings and 6 plates. Cloth, \$1.00, net. The Medical Epitome Series. Lea & Febiger, Publishers, Philadelphia and New York, 1912.

As a concise presentation of the essential points of bacteriology and microscopy this little work has won the favor of students and practitioners. In its new edition the scope has been broadened to include some of the protozoa, an improvement which should increase its usefulness to the practicing physician and to the advanced student. The features which gained for it the approbation of its readers have been continued in the present very thorough revision.

**A Treatise on Tumors.**—For the use of Physicians and Surgeons. By Arthur E. Hertzler, M. D., of Kansas City, Mo., Assistant Professor of Surgery in the University of Kansas. Octavo, 728 pages, with 538 illustrations and 8 plates. Cloth, \$7.00, net; half Persian morocco, gilt top, de luxe, \$9.00, net. Lea & Febiger, Publishers, Philadelphia and New York, 1912.

Approximately one-fourth of all surgical literature is devoted to tumors. This fact alone conveys some idea of the magnitude and importance of the subject, and should impress on the busy physician, surgeon and specialist the impossibility of even beginning to read this vast mass and the great difficulty of finding therein any particular information for which he may be in search. In the volume at hand, Dr. Hertzler has presented, in such proportion as his duties as teacher and consultant have shown to be most advisable, the experience of many years gained in the operating-room, the observations of laboratory study, and the information gathered from the literature. To make his volume one of maximum utility he has, in presenting the subject, kept in mind the application of both the scientific viewpoint and clinical observation. The practical aspects have received strong emphasis. The volume is one which brings the general practitioner and surgeon into co-operation. It is sumptuously illustrated with original engravings and plates.

**Food Values.** Practical Tables for Use in Private Practice and Public Institutions. By Edwin O. Locke, A. M., M. D., Instructor in Medicine, Harvard Medical School. New York and London. D. Appleton & Co. 1911.

In this little volume of more than 100 pages the author has brought together from various sources exact information regarding the composition and nutritive value of all the common foods in a form so simple that it can be readily applied to the every day regulation of diets. It will prove of great help to physicians and to dietitians in arranging diets for private practice or for hospitals and other institutions.



# Prize Winners

The committee of judges who examined the articles submitted to us in competition on the subject of

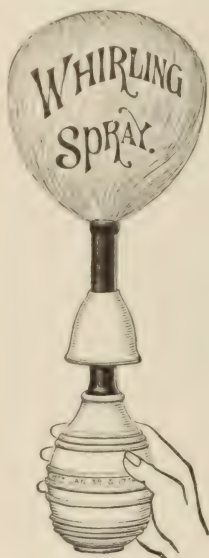
## Vaginal Douche Therapy

have rendered their decision, awarded the prizes, and checks have been mailed to the following physicians:

L. Porsenna Solsman, M. D., 137 Blue Hill Avenue, Boston, Mass.	1st prize, \$300.00
W. T. Marrs, M. D., Peoria Heights, Ill.	2nd " 200.00
Nelson du Val Brecht, M. D., 609 22nd St., N. W., Washington, D. C.	3rd " 150.00
Dr. Leonard Keene, Hirshberg, 1937 Madison Ave., Baltimore, Md.	4th " 125.00
Franklin Perry, M. D., Parkers Prairie, Minn.	5th " 100.00
Frederick V. Mohn, M. D., 4 & 5 Sepulveda Bldg., San Pedro, Cal.	6th " 75.00
Dr. William Brady, 1008 Lake Street, Elmira, N. Y.	7th " 50.00
	<hr/> \$1000.00

Respectfully,  
MARVEL COMPANY.

Makers of Marvel "Whirling Spray" Syringe



## Healthy Children

are the most valuable asset of a nation

## BORDEN'S EAGLE BRAND CONDENSED MILK

provides suitable infantile nutrition for a strong  
and robust maturity

*Sample and Analysis sent upon receipt of professional card*

BORDEN'S CONDENSED MILK CO.

"Leaders of Quality"

Est. 1857.

NEW YORK

**Married.** Dr. and Mrs. John Rockhill Fleming announce the marriage of their daughter, Lucy Emma, to Mr. Stanley Jacob Theis, on Tuesday, the 20th of February, 1912, Atlantic City, N. J.

Mr. and Mrs. John Hopkins Mara announce the marriage of their daughter, Mrs. Mary Gertrude Wright, to Dr. Clarence Bartlett, on Thursday, the fourth of April, 1912, in the City of New York.

Mr. and Mrs. Samuel Eugene Kuen announce the marriage of their daughter, Mary Clark, to Dr. Charles Daniel Fox, Jr., Thursday, the fourteenth day of March, 1912, Cynwyd, Pa. Dr. and Mrs. Fox have sailed for Europe and expect to return home about the middle of October.

**Obituary.** Dr. Robert G. Whinna died on February 2, 1912, at the home of his son, Dr. Elmer G. Whinna, No. 320 North Forty-first street, Philadelphia. Dr. Whinna, who was a noted Methodist minister, took up the study of medicine with his son at the Hahnemann Medical College, Philadelphia, and they were graduated together in 1891. Dr. Whinna was seventy-three years of age.

Ralph Bernstein.

**Notice.** A physician, who will conclude hospital service as resident is desirous of doing relief work for a physician from June until November, 1912. Physicians desiring to go on their vacations during this period of time and anxious to have someone attend to their routine of duties will kindly address F. L. B., care of Hahnemannian Monthly.

**Resident Physician Wanted.** During May and June several vacancies in the house staff in the Grace Hospital, Detroit, will be filled. Grace Hospital, since its addition was completed, is the newest and best equipped Homœopathic Hospital in the United States. Last year there were treated in the hospital 3615 cases, medical, surgical, obstetrical, 580 more than in 1910. The average daily number is 175. A small remuneration is given to some of the house staff. Applicants should write Stephen H. Knight, M. D., 37 East Willis avenue, Detroit, chairman of examination committee.

**Location Wanted.** Graduate "Old Hahnemann," Philadelphia; fourteen years' successful professional experience (some surgery)), desiring larger field, seeks bona-fide location, industrial town, 5,000 or more with good schools, churches (Protestant); suburban railroad facilities, New Jersey or Pennsylvania only, where fees and collections are good; county seat not objectionable; established practice \$3,000 or more with proper opportunities for specializing in chronic diseases, of physician removing or retiring preferred; would purchase introduction on reasonable terms and rent old stand if possible. No real estate bought; no agents. Give full particulars first letter. Address, "Location," care of "Hahnemannian Monthly," 1631 Arch street, Philadelphia, Pa.

**The Philadelphia Society for Clinical Research,** held its regular monthly meeting at the office of Dr. Wm. M. Sylvis, 1903 South Broad street, Philadelphia, Pa., on Wednesday, March 20, 1912. Two papers were presented for discussion. One by Dr. G. Harlan Wells, entitled "Rheumatic Fever," and one by Dr. Wm. M. Sylvis, entitled "Tumors of Breast." A very enjoyable time was had by all those who attended the meeting.

Walter J. Snyder, M. D., Secretary.

**Personals.** The sum of \$200,000 has been raised towards the completion of an endowment fund of \$1,000,000 for the Hahnemann Hospital, according to an announcement made recently by Charles D. Barney, President of the Board of Trustees of the institution, at a meeting of the Hospital Association in the Bellevue-Stratford.

The State Board of Examiners inspected the methods of teaching at the Hahnemann Medical College and Hospital on Wednesday, February 14th. at 2 P. M., and they were uniformly pleased and gratified with the modern methods of teaching, and the unexcelled facilities at the institution.

A dinner under the auspices of the Hahnemann Medical Club, was given in honor of the fiftieth anniversary of Dr. Caleb L. Middleton as a practitioner, on Wednesday evening, April 10, 1912, at 7.30 o'clock, at the Union League of Philadelphia.

Dr. Joseph E. Wright, who for over twenty-five years has been connected with the larger New York hospitals, has succeeded to the practice of the late James S. Hickey, M. D., of 1839 North Eleventh street, Philadelphia, Pa.

Dr. Gilbert J. Palen, announces the removal of his office to 2102 Chestnut street, Philadelphia, Pa.

Dr. Walter H. Hatfield, a recent graduate of the Hahnemann Medical College, Philadelphia, Pa., has opened his offices in The Dexter, Woodburn and Dexter avenues, Cincinnati, O.

Dr. W. Nelson Hammond announces the removal of his offices to the Weightman Building, No. 1524 Chestnut street, Philadelphia, Pa. Hours, 9 to 11 A. M., 5 to 6 P. M.

Dr. Arthur Hartley announces the opening of his office at No. 1302 Spruce street, Philadelphia, Rectal diseases. Hours, 10 to 11.30 A. M.

Dr. Henry I. Klopp, a graduate of Hahnemann Medical College, Philadelphia, at a recent meeting of the trustees of the State Homœopathic Insane Asylum at Rittersville, Pa., was chosen superintendent. Dr. Klopp is a native of Lebanon, Pa., and for the past seventeen years has been connected with the management of the Massachusetts Homœopathic Asylum at Westborough. Dr. Klopp was at the meeting, having come on from Massachusetts by invitation.

Dr. W. W. Speakman has been elected consulting ophthalmologist at Wilmington Homœopathic Hospital.

Dr. Frank O. Nagle recently read a paper before the Cleveland Homœopathic Medical Society on "Neurosis of the Eye."

Dr. John A. Lenfesty, of Mt. Clemens, Mich., has opened an office at 257 Woodward avenue, Detroit, Mich. Dr. Lenfesty will continue his office at Mt. Clemens as before.

Dr. C. N. Shellenberger announces the removal of his office to his residence, second floor, No. 4 Colchester Apartments, corner Tejon and Vrain streets, Colorado Springs. Hours, 9.30 to 10.30, 2.30 to 3.30 and 7 P. M.



# Pennsylvania State Society News

## JOURNAL COMMITTEE

D. P. Maddux, M. D.

Harry S. Weaver, M. D.

Ralph Bernstein, M. D.

**American Institute of Homœopathy, Special Membership Committee.**  
The special membership committee, appointed by Dr. G. J. Palen, President of the Homœopathic Medical Society of the State of Pennsylvania, consisting of Drs. Francis Boyer, of Pottsville, Pa.; J. P. Craig, of Chester, Pa.; W. A. Hamen, of Reading, Pa.; H. F. Heilner, of Scranton, Pa.; T. M. Johnson, of Pittston, Pa.; I. D. Metzger, of Tyrone, Pa.; T. Pratt, of Media, Pa.; J. H. Swick, of Beaver Falls, Pa.; H. F. Schantz, of Reading, Pa.; W. A. Stewart, of Pittsburgh, Pa.; E. L. Nesbit, of Bryn Mawr, Pa., and Ralph Bernstein, Chairman, of Philadelphia, Pa., hereby earnestly solicits your membership for the American Institute of Homœopathy.

Pennsylvania's loyalty and devotion to the cause has never been questioned, and her State Society with its seven hundred members, stands pre-eminently as the best organized Homœopathic State Medical Society in the Union.

Pennsylvania's endorsement of the Institute has been sadly neglected. There are somewhat less than three hundred Pennsylvania homœopaths who endorse the National Society, "The Institute," with their membership. It is, therefore, up to Pennsylvania to establish her reputation as a supporter and endorser of our national organization.

It may be, perhaps, that your membership has never been properly solicited. If such is the case, the Membership Committee is endeavoring to make a systematic canvass of this State for new members for the Institute, which meets in our State at Pittsburgh in June next, 16th to 22nd. Application blanks have already been mailed you. If you are already a member the committee congratulates you for endorsing your National Society, and would beg of you to use the application blank in seeing that someone else becomes a member. If you are not a member of the Institute, the committee still hopes to be able to congratulate you for your loyalty to the cause.

Fill out application blank, sign and forward same to the chairman, with check for \$5.00, which includes everything for the first year, reminding you of the Institute Journal which comes to you monthly.

Ralph Bernstein, Chairman,  
No. 37 South Nineteenth Street,  
Philadelphia, Pa.

**An Interesting Announcement is Made in this Issue by the H. K. Mulford Company concerning Meningo-Bacterin (Meningococcus Vaccine).** Bacterin therapy is long past the experimental stage, and the immunizing effect of typho-bacterin, for instance, is thoroughly established, the results from its use being sufficient evidence of the worth of this method of controlling the spread of typhoid fever. Remarkable results likewise have followed the use of cholera-bacterin and it is hoped that equally good results will follow the use of meningo-bacterin

in controlling epidemics of cerebro-spinal meningitis. While immunization with meningo-bacterin has thus far been used in relatively few cases it is entirely reasonable to believe that it will prove a most valuable aid in the suppression of epidemics of cerebro-spinal meningitis.

**Directions.**—The usual site for inoculation is the arm at about the insertion of the deltoid muscle. The dose is given subcutaneously and not in the muscle nor into the skin. An area about the size of a five-cent piece is painted with tincture of iodine. The syringe needle is plunged through this area. No after treatment is necessary.

The complete immunization treatment consists of three doses, given at intervals of from five to ten days. The first dose is 500 million, the second dose 1,000 million and the third dose 1,000 million.

For children smaller doses should be used according to weight. It has been suggested that the unit of body-weight for a full dose be considered 150 pounds.

**Functional Heart Disease.**—It has long been known that Cactina Pillets are especially serviceable in all functional disorders of the heart, as well as in certain phases of the common organic lesions.

They are safe, reliable, and do not manifest a cumulative action. Associated with digitalis, Cactina Pillets act as a valuable synergist, making possible the use of much smaller doses of digitalis in the production of desired effects.

As has been previously said, Cactina Pillets improve cardiac nutrition. Under its use the heart's action is slowed and materially strengthened. No miraculous claims have ever been made for Cactina Pillets, but in suitable cases clinical experience has repeatedly demonstrated its extraordinary value as a persuasive tonic.

**Resolution Adopted.** At a meeting of the Boston Section of the Massachusetts Homœopathic Medical Society, the following resolution was offered and unanimously adopted: Resolved, That we, the Boston Section of the Massachusetts Homœopathic Medical Society, in session assembled declare ourselves as having no allegiance nor sympathy with the League for Medical Freedom. That we are opposed to its methods and aims, and we further protest against the use of our name as a school in its propagandistic work.

(Signed) William A. Ham, Secretary.

**The Homœopathic Medical Society of the County of Philadelphia,** held its regular monthly meeting at Hahnemann Medical College, Philadelphia, Pa., on Thursday evening, March 14, 1912. The scientific program of the evening consisted of the following papers: "Diagnosis and Treatment of Gastric and Duodenal Ulcer," Dr. Thomas Bradley; Discussion—"Medical Treatment," Dr. Harry Eberhard; "Surgical Treatment," Dr. H. L. Northrop; "Report of Two Cases," Dr. Mary Cooke; "The Homœopathic Remedy in the Treatment of Nausea and Vomiting of Pregnancy," Dr. J. E. James, Jr.; "Digitaline," Dr. O. H. Paxson.

Wm. M. Sylvis, M. D., Secretary.

**The Clinico-Pathologic Society of Philadelphia,** held its regular monthly meeting at Hahnemann Medical College, Saturday evening, March 16, 1912. The scientific program of the evening consisted of the following papers: "Some Interesting Surgical Cases," Dr. D. Roman; "Nasal Reflexes," Dr. H. S. Weaver; "Glandular Fever," Dr. C. F. Raue.

Benj. K. Fletcher, M. D., Secretary.

# FELLOWS' SYRUP of HYPOPHOSPHITES

A uniform result may always be confidently  
expected from this faithfully-prepared and  
long-tried preparation

*Reject* < Worthless Substitutes  
Preparations "Just as good"



The Homœopathic Medical Society of the Twenty-Third Ward of Philadelphia, held its regular monthly meeting at the office of Dr. Robert S. Summers, 2610 North Twenty-First street, Philadelphia, Pa. An interesting paper on "Colic" was read. The meeting was well attended and enjoyed by all present.

John D. Boileau, M. D., Secretary.

The Oxford Medical Club, held its regular meeting at the office of Dr. Percy H. Ealer, 2027 Spring Garden street, Philadelphia, Pa. An interesting paper was read on "Eczema—Synopsis for the General Practitioner," by Dr. Percy H. Ealer. The meeting was well attended, and enjoyed by all.

C. W. Simmons, M. D., Secretary.

The Delaware County Homœopathic Medical Society, held its regular monthly meeting in the Y. M. C. A. Building, Seventh and Edgmont avenue, Chester, Pa., on Thursday afternoon, at 3.30 P. M. Dr. Ralph Bernstein, of Hahnemann College, Philadelphia, Pa., gave a very interesting "Stereoscopic Skin Clinic, with Lantern Demonstration of the More Common Skin Diseases, Their Recognition and Treatment." Dinner was served at 5 P. M.

The Women's Homœopathic Medical Association of Pittsburgh, Pa., held its regular monthly meeting at the office of Dr. Lydia Baker Pierce, 2053 Murray avenue, Pittsburgh, Pa., on Thursday evening, April 11, 1912. The symposium of the evening being on "Diarrhea Differentiation of Remedies."

Mary E. Coffin, M. D., Secretary.

The Homœopathic Medical Society of Chester, Delaware and Montgomery Counties, held their Hahnemann Anniversary and Easter celebration in the Y. M. C. A. rooms, at Chester, Pa., on Tuesday afternoon, April 9, 1912, at 1 o'clock. The scientific program consisted of the following: "The Wassermann Reaction; Its Principles and Values," Dr. R. S. Leopold; "The Use of Salvarsan (606) in Syphilis," Dr. J. M. Kenworthy. A planked shad dinner was served at 2 o'clock, which proved to be a very enjoyable feature of the meeting.

Isaac Crowther, M. D., Secretary.

**After the Baby Comes.** The weakness and debility which usually follow childbirth are all too prone to linger. The burden of lactation is very apt to further prolong convalescence and increase the liability to all manner of complications. In such cases, vigorous tonic treatment is urgently required and the resulting reinforcement of vital processes promptly changes the situation.

Gray's Glycerine Tonic Comp. is peculiarly serviceable as a reconstructive and restorative for the nursing mother, not only because of its notable efficacy in promoting functional activity throughout the body, but especially because of its freedom from all contraindications. Thus it can be freely administered both during pregnancy and thereafter without a fear of its producing any but the most substantial benefits to the offspring as well as to the mother. Few remedies are more effective for increasing the lacteal flow than "Gray's," inasmuch as it exerts its

influence through improving the whole bodily nutrition rather than by stimulating a single function at the expense of the rest of the body.

**Abdominal Support Without Discomfort.** To many a patient, particularly if nervous and irritable, an abdominal bandage or binder that provides adequate support is a source of extreme discomfort. This refers to the usual binder. But through the use of the Storm Supporter all this annoyance is avoided, since it is so accurately adapted to the anatomy and shape of the mid-region of the body, that maximum support is afforded with minimum pressure and constriction. Indeed the unique feature of the Storm Binder is the frequency with which squeamish and fretful patients refer to the comfort it affords them. "I would never know I was wearing a band, but for the relief I obtain," says one. "The Binder fits and feels so good, it seems like part of my wearing apparel," says another. The advantage of all this in caring for obstetric and post-operative cases must be apparent. It goes far to account moreover for the remarkable success the Storm Binder has won among surgeons and obstetricians all over the country.—(*American Medicine*, February, 1912.)

**The Homœopathic Medical Society of the State of New Jersey**, will hold its next meeting at the Hotel Chalfonte, Atlantic City, May 8th, 9th and 10th. The President, Dr. Atkinson, is making unusual efforts to secure a large meeting and calls upon all homœopathic practitioners in the State to aid in the biggest and best demonstration ever made for homœopathy in the State of New Jersey.

**The Atlantic City Homœopathic Medical Club** held its fourth annual open meeting at the Marlborough-Blenheim Hotel, Atlantic City, on Friday evening, March 22, 1912. The scientific program consisted of a paper and demonstration by Dr. Leon T. Ashcraft, of Philadelphia, Pa., on the "Treatment of Bladder Tumors by Fulguration," with the report of cases and the stereopticon demonstration of same. After the scientific program luncheon was served and a large number of guests from Philadelphia and other cities were present.

**The Meissen.** The resident members of the Meissen in Pittsburgh have planned a number of entertainments to be given the visiting ladies. Among these will be: Luncheon and cards at the Country club, automobile ride and garden party, musical and refreshments, etc., etc. There will be more or less sight-seeing and there are many sights to see. Mrs. J. H. McClelland, President; Mrs. R. S. Marshall, Chairman of Entertainment Committee, assisted by Mrs. W. Alvah Stewart; Mrs. Verner S. Gaggin, Chairman of Hospitality Committee, assisted by Mrs. S. M. Rinehart.

**The Philadelphia Academy of Medicine** held its regular monthly meeting at the Hotel Walton, Broad and Locust streets, on Thursday evening, March 7, 1912, at 9 P. M. President Wm. H. Yeager in the chair. The scientific program consisted of a paper by Dr. Glen I. Bidwell, of Rochester, N. Y., on the "Homœopath's Trinity." The discussion was heartily participated in by guests and members, Dr. O. S. Haines making the opening remarks.

W. K. McKeever, Secretary.

**The Neglected Therapy of Convalescence.** The physician of education and experience, who keeps in touch with the progress of medicine generally, is well informed as to the treatment of most of the "thousand and one" ills that he is called upon to combat. The diagnosis and treatment of acute conditions as well as the successful management of the more chronic affections, are subjects which he is constantly investigating and studying. It so happens, however, that after the dangerous shoals of medical navigation have been successfully negotiated and when the crisis or danger point has been passed, the physician is all too liable to relax his vigilance and to allow the patient to convalesce without sufficient attention to the therapeutic details of this important period. While the feeding of the convalescent is of great importance, the medicotonic treatment is equally essential, in order to improve the appetite, tone the digestive, assimilative and eliminative functions generally and to hasten the time when the patient shall be once more "upon his feet." Among all of the general reconstituent and supportive measures in the therapy of convalescence, none is more essential than the reconstruction of a blood stream of vital integrity and sufficiency. Pepto-Mangan (Gude) is distinctly valuable in this special field, as it furnishes to the more or less devitalized blood the necessary materials (iron and manganese) in such form as to assure their prompt absorption and appropriation. One especial advantage of administering these hematinics in this form, is that digestive disturbance is avoided and constipation is not induced.

**Sleeplessness.** Insomnia is a condition which is met with almost daily, yet it is one which is treated only too frequently in some routine fashion, and often enough baffles treatment altogether. In the case of persons sleepless owing to troubles, says Dr. C. Willet Cunningham, writing in "The Hospital," words of wisdom will be more valuable than even the most ingenious prescription. There remain, however, a number of patients who have nothing on their minds and yet cannot sleep. In some there is a family tendency, in others a habit has grown perhaps from small beginnings. These are exceedingly difficult to manage successfully. In this class of sleeplessness one should have the bedroom absolutely dark and quiet at night. Ventilation is also important. Cold feet will keep other people awake. In habit cases it may help to advise a change of bedroom or even of house for a time. The evening meal is an important matter, but no general rule can be laid down. The late dinner of the full-blooded, over-nourished man needs curtailing, while the thin, dyspeptic, nervous woman requires more nourishment. For them some easily digested milk food, such as Benger's Food, the last thing at night, is useful. Tea and coffee are best avoided, especially in the latter part of the day. A "nightcap" has its obvious objections. Extra pillows are useful. The patient should spend as much time as possible in the open.

Above all, Benger's is the food for restful nights. It is so easily digested and so soothing and agreeable, that while giving full nourishment to the system, it really promotes sound, healthy sleep.

Benger's Food is mixed with new milk when prepared. It forms a dainty and delicious cream, entirely free from rough and indigestible particles. Infants thrive on it and aged people enjoy it. The composition is known, to, and approved of, by medical men.



# THE HAHNEMANNIAN MONTHLY NEWS AND ADVERTISER

A Medical Newspaper

MAY, 1912

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**Urology, The Diseases of the Urinary Tract in Men and Women.**—A book for practitioners and students by Ramon Guiteras, M. D. (Harv.), Professor of Genito-Urinary Surgery, New York Post-Graduate Medical School, etc., with nine hundred and forty-three illustrations in text and seven plates. New York and London. D. Appleton & Company, 1912.

This work on urology includes all the diseases of the urinary tract both medical and surgical in men and women. The first part of the book is preparatory to the second. It contains the anatomy of the urinary organs and of the laboratory methods of examining the urine, discharges and blood. The technique employed in using special instruments that compose the armamentarium of the urinary surgeon such as the urethro-scope and cysto-scope, is carefully described. A lengthy description of the general and special urinary symptoms and disturbances of urination are

then carefully entered into. The history and examination of the patient, following the manner of arriving at a diagnosis, is then taken up. This is followed by a chapter on urological therapeutics in which drugs, exercise, diet and use of water internal and external as well as by rectum, etc., are fully considered.

The second part of the work is principally clinical and operative, and the diseases of the various urinary organs—the kidneys, bladder, prostate and urethra are taken up seriatim. A chapter on syphilis completes the volume.

Throughout the entire work the writer has considered principally etiology, diagnosis and treatment of diseases under consideration, but has not gone deeply into their pathology. The book is profusely illustrated and the various steps in operations are shown by appropriate pictures.

The complete work is contained in two volumes and is, unquestionably, one of the most exhaustive and practical treatises on the subject of genito-urinary disease now before the profession.

**Nervous and Mental Diseases.** The New (7th) Edition.—Nervous and Mental Diseases. By Archibald Church, M. D., Professor of Nervous and Mental Diseases and Medical Jurisprudence in Northwestern University Medical School, Chicago; and Frederick Peterson, M. D., Professor of Psychiatry, Columbia University. Seventh edition revised. Octavo volume of 932 pages, with 338 illustrations. Philadelphia and London: W. B. Saunders Company, 1911. Cloth, \$5.00 net; half morocco, \$6.50 net.

This classical work, now in its seventh edition, still remains one of the most popular books in its sphere. A detailed description of its contents would be superfluous and it is sufficient to say that it covers the entire field of nervous and mental diseases in a way that the medical practitioner has placed before him clearly and briefly all the important data relating to the diagnosis and treatment of these diseases.

In the seventh edition a number of chapters have been re-written, particularly those dealing with meningitis, polio-myelitis and pellagra. The section on mental diseases has been rearranged in accordance with recent methods of classification and much new matter has been added. It is a work which can be highly recommended as being both practical, complete and reliable.

**Diseases of the Nose and Throat.**—Comprising affections of the trachea and oesophagus, a text-book for students and practitioners, by St. Clair Thomson, M. D., F. R. C. P. (Lond.), F. R. C. P. (Eng.) Physician for Diseases of the Throat and Professor in Laryngology in King's College Hospital, etc., with eighteen plates and two hundred and ninety-four figures in the text. New York, D. Appleton & Company, 1912. Price, \$7.50.

In writing this work Dr. Thomson has endeavored to convey to his readers the knowledge he has gained from a wide personal experience in the management of diseases of the nose and throat. No attempt has been made to give a complete account of the anatomy or physiology of the regions studied, but special stress has been laid on the clinical and pathological bearings and on the natural defense and repair.

A full description of symptoms and of the methods of diagnosis have been given and the author has made free use of diagram-

matic sketches in order to elucidate the details of examination and treatment. Operative measures have been described with considerable fullness, especially those that might fall within the sphere of the general practitioner.

The work contains numerous helpful illustrations both plain and in colors. We are impressed with the thoroughness with which the ground is covered and the very practical manner in which the author has presented his subject.

**"Maltose in Infant Feeding,"** is the title of a very interesting pamphlet now being put into the hands of the general practitioner by the Mellin's Food Company.

It deals with the question of carbohydrates in the feeding of infants, giving opinions of the comparative value of sugars employed in the modification of milk, and presenting much evidence of a convincing nature as to the superiority of maltose and dextrin for the carbohydrate content of a baby's diet.

Opinions of physicians whose extensive experience entitles them to a respectful hearing seem to show that these combined carbohydrates have a wide range of utility, giving results in intestinal disturbances and in the feeding of well babies that are highly satisfactory.

Requests for copies of "Maltose in Infant Feeding" addressed to the Mellin's Food Company, Boston, will have prompt attention.

**Physical Diagnosis.** Second Edition, Revised. Principles and Practice of Physical Diagnosis. By John C. DaCosta, Jr., M. D., Assistant Professor of Clinical Medicine, Jefferson Medical College, Philadelphia. Second edition, revised. Octavo of 557 pages, with 225 original illustrations. Philadelphia and London: W. B. Saunders Company, 1911. Cloth, \$3.50 net.

The purpose of this book is to present, within reasonable compass, the principles of physical diagnosis and to apply those means of research to the study of thoracic and abdominal diseases.

Special consideration is given to clinical anatomy and to the mechanism and meaning of physical signs, both normal and abnormal.

After reviewing the general principles of physical diagnosis, the author takes up the diagnostic features of the various diseases affecting the abdomen and chest.

The work is especially adapted to the needs of medical students and to medical practitioners who desire to perfect themselves in this very important branch of medical art.

**Differential Diagnosis.** Second Edition, Revised. Differential Diagnosis. Presented through an Analysis of 385 Cases. By Richard C. Cabot, M. D., Assistant Professor of Clinical Medicine, Harvard Medical School. Second Edition. Octavo of 764 pages, illustrated. Philadelphia and London: W. B. Saunders Co., 1912. Cloth, \$5.50 net.

We are not surprised that this work has reached its second edition within a year. It is one of the few books that the over-worked physician can sit down and read as he would an entertaining novel.

Dr. Cabot has presented the facts relating to the differential diagnosis of the various diseases under consideration by means of an analysis of 385 cases covering almost as many disease conditions. Fol-



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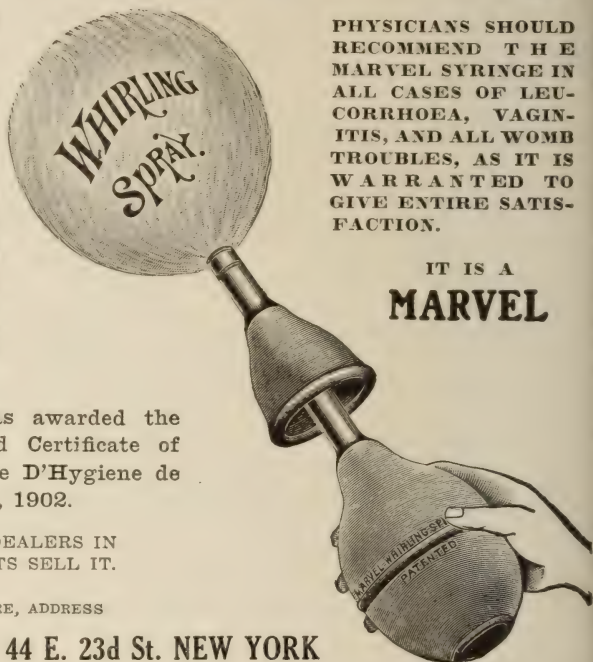
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## Homœopathic Medical Society *of the* State of Pennsylvania

*Annual Meeting*  
DELAWARE WATER  
GAP :: September  
17, 18 and 19, 1912

lowing the history he has given an analysis of the clinical date that enabled him to reach the diagnosis and also a statement as to the outcome of the case.

Numerous illustrations and diagrams have been inserted explanatory to the text and a great deal of valuable clinical information seldom found in the stereotyped text-book on medical diagnosis, is presented.

**Modern Methods in Nursing.**—Modern Methods in Nursing. By Georgiana J. Sanders, formerly Superintendent of Nurses at the Massachusetts Hospital, Boston. 12mo. of 881 pages, with 228 illustrations. Philadelphia and London: W. B. Saunders Company, 1912. Cloth, \$2.50 net.

It is by no means an easy matter to find a text-book that will fit the curriculum required by modern training schools for nurses, and the author of the volume now before us is to be congratulated upon the way in which she has succeeded in condensing within the pages of a single volume of 881 pages, the greater part of the information that a nurse is likely to need.

The subjects touched upon are quite numerous. For example, we find chapters on bed-making, baths, local applications, enemata and douches, methods of taking pulse, temperature, respiration, etc., bandages and splints, poisons and their antidotes, surgical sepsis, care of operation cases, preparation of food, diets and dieting. The wide experience of the author together with the assistance which she has had from some of the most prominent authorities, in certain portions of the work, has contributed to make it an eminently accurate and useful one for the nurse in training and also for the medical student who desires to familiarize himself with some of the practical features of medical work.

**The Treatment of Nervous Disorders.**—Valuable as are rest and dietetic regulation in the treatment of nervous disorders, it is generally recognized that effective tonics are always necessary. For instance, in chorea and the restorative stage of poliomyelitis, it is often surprising to note the remarkable impetus given to convalescence by the use of Gray's Glycerine Tonic Comp. Its administration promptly stimulates the appetite, aids digestion, and so improves the whole nutrition that recovery is substantially furthered and hastened. The same thing holds true in neurasthenia, and the benefit that almost always follows the use of the remedy is invariably as gratifying to the practitioner as it is to the patient.

**Personals.**—Dr. Barrett Conner Catlin, who has been Secretary of the Maryland State Homœopathic Medical Society for twelve years, declined re-election.

Dr. Joseph S. Garrison, who has been Superintendent and Gynaecologist at St. Luke's Hospital, Baltimore, for several years, has gone to Chilcothe, Ohio, to practice.

Miss Elizabeth Hurren, Superintendent of Nurses and Acting Superintendent of St. Luke's Hospital, Baltimore, expects to leave June 1st for a rest and may enter the government service. She is a graduate of Ann Arbor, Michigan University Hospital.

Dr. Charles H. Robelen is recovering from an attack of typhoid fever and will soon be able to resume his professional practice. Dr. Robelen

has recently removed his office from 1200 South Fifty-second street, to 304 Flanders Building, Philadelphia, Pa.

Dr. E. R. Richie, of Moorestown, N. J., has removed to Oak street, Brewster, N. Y.

Doctor W. Nelson Hammond announces the removal of his office to 313 Weightman Building, 1524 Chestnut street.

Dr. Dandolo Matteli announces the removal of his office to 52, Via Montebello, Florence, Italy.

The Training School for Nurses, the Women's Southern Homœopathic Hospital, of Philadelphia, held its commencement exercises on Thursday evening, April 19, 1912, at 8 o'clock, Memorial Building, First Presbyterian Church, N. E. corner Seventh and Spruce streets, Philadelphia, Pa.

Dr. F. W. Koons announces the removal of his office to corner of Shiloh and Sycamore streets, Pittsburgh, Pa.

Dr. G. J. Alexander, of 557 North Sixty-third street, Philadelphia, has sailed for Vienna where he expects to devote a year or two to the study of diseases of the ear, nose and throat.

**Wanted.**—Substitute work for months of July, August and September by a Hahnemann graduate of 1910, with two years' experience in hospital and relief work. Address, H. M. C., care of "Hahnemannian Monthly."

**Alpha Sigma Fraternity.**—Members of Alpha Sigma Fraternity in attendance at the meeting of the American Institute of Homœopathy at Pittsburgh, June 16-22, will hold their annual Institute reunion. Our alumni residing at Pittsburgh are providing for the reception and entertainment of the brothers. Fraternity headquarters have been reserved at the Hotel Shenley. Members are urged to register at once upon their arrival that they may receive full information as to the program provided. These yearly fraternity meetings afford many of the most enjoyable and memorable events in our fraternity life. To the active chapter members they give the opportunity of coming in close fraternal associations with many of the most prominent men in our profession; and an opportunity is given to the alumni to renew more closely their old fraternal associations and keep in touch with the fraternity's progress. Several of the grand officers are always in attendance, and a short business session is held for discussion of matters pertaining to the fraternity's welfare. Should any additional inducement be necessary to decide one upon attending this meeting of the American Institute, surely this notice to Alpha Sigma men is all that is necessary.

Wm. H. Price, M. D., Grand Secretary.

Dana F. Downing, M. D., Grand President,

The Annual Dinner of the Alumni Association of the Hahnemann Medical College of Philadelphia, will again be given in the Clover Room of the Bellevue-Stratford on Thursday evening, June 6th, at 6.30 o'clock. Last year there were about two hundred and fifty present and this year all records for attendance are expected to be broken. As last year the seating will be by classes and the classes which were in college together will be placed near each other. In this way the dinner will be a real



reunion and it is hoped class and college spirit will be kept alive and nourished. A number of classes are making elaborate preparations to insure a big attendance, particularly 1902 who will celebrate their decennial reunion.

Dr. L. P. Posey will act as toastmaster and among the speakers will be the Rev. Dr. Steele, rector of St. Lukes; Dr. William H. Keim, President of the Alumni Association; Dr. Gilbert J. Palen, President of the Pennsylvania State Society, and Dr. D. P. Maddux of the Bureau of Medical Education and Licensure of Pennsylvania.

Notice has been sent to each alumnus at his last known address and if any one has failed to receive such a notice he can have a place reserved for him by sending his name, class and five dollars to the Chairman, Dr. J. D. Elliott, 1421 Spruce street, Philadelphia, before June 3rd.

The Philadelphia Alumni will entertain the Alumni Association at a smoker at the Continental Hotel on Wednesday evening, the night before the dinner. Dr. John A. Fisher, chairman, has arranged a very interesting program and expects lots of enthusiasm, songs and a general good time. Every one will be welcome.

The annual meeting of the Alumni Association will be held in the college on the afternoon of June 6th. Some very important business will come before the meeting and every one who can do so is requested to be present and do his share to help the Association in its work of booming the college.

**Sense and Science in Feeding.**—Sir James Brown, in a recent article, contended that it was of the utmost importance that good flavor and good aroma should prevail, for nice food is more easily assimilated than that which is flavorless. The most ideal invalid food, from not only the scientific but gastronomic aspect, is Benger's, because it is easily assimilated, is acceptable to the patient, will not produce toxemia, is purin free, and can be adapted to suit the most weakened gastric condition; it supplies the necessary amount of carbohydrate, fat, and protein that is needed to maintain the body in a state of nutritive equilibrium.

Benger's Food is specially prepared to build up the weakened digestive system, and to promote a high state of nutrition while doing so; it is not a predigested food, nor does it contain dried milk. It is made with fresh milk, and forms a dainty, delicious cream, with a delicate flavor.

Benger's Food enjoys the confidence and support of leading medical authorities, and has been employed with success in the dietary treatment of marasmus, inanition, typhoid fever, gastritis, gastric ulcer, dysentery, post-operative and convalescence from acute illnesses, etc., etc.

**The Safest and Most Efficient of Modern Hypnotics.**—This distinction is now fairly unanimously accorded everywhere to Medinal, a readily soluble substance which can be administered by mouth, by rectum and subcutaneously, and is so quickly absorbed and so promptly eliminated from the organism that for rapid action and absence of cumulative by and after-effects it has no equal. It is also an excellent sedative used with considerable success in the treatment of alcohol and drug addiction, as well as in psychiatric practice. Many of the largest hospitals, sanitarium and insane institutions have adopted Medinal permanently as a general hypnotic.

**Plasmodial Anemia.**—In spite of the modern theory of the etiology of malaria and malarial affections (mosquito-borne infection) this plas-

modial disease continues to be rife in certain sections of the country and bids fair to be, like "the poor," "always with us."

Every physician of experience appreciates the principles which should guide him in the treatment of the various acute manifestations of paludal poisoning, i. e., the destruction of the plasmodial hosts which have invaded the blood and which, if not eliminated, consume and destroy the red cells, the vital element of the circulating fluid.

When this purpose has once been accomplished the patient is but partly cured; the damage done to the red corpuscles must be repaired and the vitality of the blood restored, if re-infection is to be avoided. If there is any one condition in which direct hematinic or blood-building therapy is positively indicated, it is in post-malarial anemia. As soon as the febrile period has passed, iron, in some form, should be given in full dosage. Pepto-Mangan (Gude) constitutes the ideal method of administering this essential blood-building agent in this as well as in any anemic condition. Both the iron and manganese in Pepto-Mangan are in organic combination with peptones and are, therefore, easily and promptly absorbed and assimilated without causing digestive derangement or producing constipation.

# Pennsylvania State Society News

## JOURNAL COMMITTEE

D. P. Maddux, M. D.

Harry S. Weaver, M. D.

Ralph Bernstein, M. D.

**Institute Membership.**—Your last chance to join the Institute, Doctor! The membership list to be handed in for the State of Pennsylvania is about completed. You still have an opportunity, if you have delayed sending in your application blank, by doing so at once. Pennsylvania must make a formidable showing at the Institute meeting on the 16th of this month, and the committee is more than anxious to present your name with those about to be presented. Misplaced your application blank? More for the asking. Write at once, and there will still be time. If you are already a member of the Institute, it is your paramount duty to see that you secure your neighbor as a new member for the Institute. The strength of any organization is measured by its numbers. Pennsylvania's organization as a State Society is unquestionably the foremost among Homeopathic State Medical Societies in the Union, and it should be Pennsylvania's aim to see that she is more than ably represented on the membership role. Do it now, and know that you have been loyal to the Homœopathic cause, which is nothing more or less than what is expected of you. Forward application blank with check for \$5.00 to the undersigned, which includes everything for the first year, reminding you of the Institute Journal, which comes to you monthly.

Ralph Bernstein, Chairman,  
37 South Nineteenth street,  
Philadelphia, Pa.

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The Homœopathic Medical Society of the County of Philadelphia, held its regular monthly meeting at Hahnemann College, on Thursday evening, April 11, 1912, at 9 o'clock. The scientific program of the evening consisted of the following: "Drug Pathogenesis and Homœopathy," Dr. Wm. A. Seibert; Discussion, Dr. A. Korndoerfer; Discussion, Dr. O. S. Haines; Discussion, Dr. E. L. Nesbit. The meeting was a very interesting one, and was well attended.

Wm. M. Sylvis, M. D., Secy.

The Germantown Homœopathic Medical Society, held its regular monthly meeting at the Majestic, Broad and Girard avenue, on Monday, the 15th of April, 1912, at 9 o'clock in the evening. Dr. Theodore J. Gramm told of "The Thermo-Cautery Treatment of Inoperable Carcinoma Cervical Uteri and its Results," which proved very interesting and was enjoyed by all present.

Landreth W. Thompson, M. D., Secy.

The Homœopathic Medical Society of the 23rd Ward, held its regular monthly meeting on Wednesday, April 17, 1912, at the office of Dr. Wm. Erwin, 4944 Cedar avenue. A very interesting paper was read on "Retro-uterine Displacement." The meeting was well attended, and enjoyed by all present.

J. D. Boileau, M. D., Secy.

The Pennsylvania Society of Physico-Therapy, held its regular monthly meeting at 9 P. M., on Tuesday, April 23, 1912, at the Hotel Walton. Dr. Benham Snow, of New York City, read a paper on "High Frequency Current in Medicine and Surgery," after which a general discussion took place and proved very interesting. The meeting was well attended and enjoyed by all members present.

Walter C. Baker, M. D., Secy.

The Clinico-Pathologic Society of Philadelphia, held its regular monthly meeting at Hahnemann College, on Saturday evening, April 20, 1912, at 8.30 o'clock. The program of the evening was as follows: "The Necessity of the General Practitioner," Dr. Jos. C. Guernsey; "Analytical Review of Five Years' Hospital Work in Gynecologic Pathology," Dr. N. S. Betts; "Pathology of Hemorrhoids," Dr. C. A. Bigler. There was a full attendance of members, great interest being shown at the meeting.

Benj. K. Fletcher, M. D., Secy.

The Women's Homœopathic Medical Association, of Pittsburgh, Pa., held its regular monthly meeting at the office of Dr. Anna Johnson, 5016 Liberty avenue, on Thursday, May 9, 1912, at 8 P. M. Discussion of the evening was on "Differentiation of Remedies in Diarrhea." The meeting was well attended, and an enjoyable time was had by all members present.

Mary E. Coffin, M. D., Secy.

The Oxford Medical Club, held its regular monthly meeting on Friday evening, May 3, 1912, at 9 P. M., at Mayer's, 1620 North Broad street. A very interesting paper on "Miscarriage" being read by Dr. A. B. Lichtenwalner.

C. W. Simmons, M. D., Secy.

**The Philadelphia Society for Clinical Research**, held its regular monthly meeting at the office of Dr. Walter Snyder, 5300 Spruce street, on Wednesday evening, April 17, 1912, at 9 P. M. The members present being entertained by Dr. Norman S. Betts, who read a paper on "The Treatment of Gonorrhoea in Women." A paper on, "The Treatment of Abortion," was read by Dr. F. Frosh, which was well presented. A report of the Committee on Clinical Research, was read by Dr. Ralph Bernstein.

Walter J. Snyder, M. D., Secy.

**Testimonial Dinner to Dr. Caleb S. Middleton.**—A testimonial dinner was given to Dr. Caleb S. Middleton, of Philadelphia, in honor of his fiftieth anniversary in the practice of medicine on Wednesday evening, April 10th, under the auspices of the Hahnemann Medical Club. The dinner was held at the Union League. A large number of representative homœopathic practitioners from Philadelphia were present. Dr. Middleton has served his profession and the homœopathic school faithfully and successfully during the fifty years of his medical career and it is indeed fitting that some such tribute should have been paid to him by his brother practitioners.

**The Goodno Homœopathic Medical Society.**—The regular April meeting of the Goodno Homœopathic Medical Society of Dauphin, Lancaster, Lebanon and York counties was held at the Bolton House, Harrisburg, April 11th. Meeting was called to order by President Brose at 11.30 A. M. Roll call, Drs. J. Ross Swartz, G. W. Hartman, C. M. Rhodes, W. E. J. Bomberger, J. H. Yeagley, C. H. Smith, J. S. Bringman, George W. Brose, Brantly F. Parker of York, S. Ulrich of Elizabethtown, H. H. Rhoads of Middletown, G. B. Weaver and H. C. Brown of Lancaster. After a brief business meeting the following program was rendered: President's Inaugural Address, Dr. Geo. W. Brose; "Homœopathy's Call to Us," Dr. Julia C. Loose; "Some Vague Liver Diseases," Dr. C. H. Smith. 1 P. M., recess. The Society were the guests of the Harrisburg members to dinner, 2.45 P. M. Society called to order by President Brose. "Nephritis," Dr. R. L. Perkins; "Diagnosis of Typhoid Fever," Dr. M. S. Bringman. After Dr. Bringman's paper was read and discussed the meeting was declared open for general discussion. Dr. R. L. Perkins (by request), "Technique of Preparing Solidified Carbon Dioxide." Drs. Swartz, Loose, Yeagley and Rhodes talked on the coming meeting of the American Institute of Homœopathy, Dr. Swartz on "The Merits of the Homœopath," and Dr. Loose on, "The Selection of the Remedy." 4.30 P. M. the Society adjourned to meet June 13th at York.

Brantly F. Parker, Secy.

**Maryland State Homœopathic Medical Society.**—The Maryland State Homœopathic Medical Society met in annual session at Hotel Emerson, Baltimore, May 1st and 2nd. Sessions were held in the afternoon and evening of each day and a banquet was given the last evening. The officers of the session were: President, Dr. H. H. Stansbury, Marlborough; First Vice-President, Dr. M. E. Shamer, 548 North Fulton avenue; Second Vice-President, Florence L. A. Evans 301 East 21st street; Corresponding Secretary, Dr. B. C. Catlin, 1404 Linden avenue; Recording Secretary, Dr. Shepperd Drain, 1031 Lanvale street; Treasurer, Dr. A. J. Davies, 3300 Chestnut street; Necrologist, Dr. G. T. Shower, 421

land avenue; Librarian, Dr. M. M. Dean, 901 North Calvert street; Bureau Chairman, Materia Medica and Therapeutics, Dr. J. A. Evans, 101 North Carey street; Gynæcology and Obstetrics, Dr. M. E. Shamer, 548 North Fulton avenue; Pædology and Orthopædic Surgery, Dr. G. G. H. Cross, 100 West 25th street; Surgery, General and Special Pathology, Dr. M. Bowman Hood, 604 North Gilmore street; Ophthalmology, Otology and Laryngology, Dr. W. Dulaney Thomas, 633 North Carrollton avenue; Organization, Registration and Statistics, Dr. Jos. S. Garrison, 848 West North avenue; Sanitary Science, Dr. G. L. Wetzel, Union Mills; Clinical Medicine, Dr. H. M. Stevenson, 1022 Lafayette avenue.

Dr. H. R. Arndt, Field Secretary of American Institute of Homœopathy, was present first and last at this meeting. Twice he addressed fair assemblages and propounded good sound reasons for our faith, courage, our remaining a minority and why we should keep everlasting ahead as we are and working out our great heritage to a greater degree of success—scientific and otherwise.

He came to us as a stranger and he goes as an elder brother. He remained with us throughout the meeting and kept up with everything even at its close. There will be quite a number of new members joined to the Institute here because of his work and the local spirit will—I said spirit, and not spirits—greatly improve for his next coming. We elected him an associate member and he will have to return.

Among visitors were Dr. Harvey of Washington, and Dr. Washburn of Wilmington, Del.

As to the program it started with announced clinics at St. Luke's and Maryland Homœopathic Hospitals, Wednesday morning. Afternoon session: Papers, "Capsicum in Throat and Ear Troubles," Dr. J. A. Evans; "Peculiar Clinical Cases," Dr. John Hood; "Edward Jenner," Dr. Fred H. Heisse; "Obstetric Procedures," Dr. A. J. Davies. Evening session: Annual address of the President, Dr. H. H. Stanbury; "The Function of the Minority in Medicine," Dr. H. R. Arndt; "Shall Candidates for Marriage Present a Certificate of Good Health?" Dr. H. M. Stevenson; "The Role of Obstetrics in Preventive Medicine," Dr. H. L. Wetzel. Thursday: "Physical Exercise," an address by Dr. William Burdick, of Public Athletic League of Baltimore; Dr. Arndt, additional remarks to evening address, "Iodine," Dr. H. G. Jones; "The Causes and Prevention of Gynecological Diseases," by Dr. Shraner. Evening session: "A New Operation in Sarcoma of the Long Bones," by Dr. G. H. Evarhard; address by Dr. Harvey of Washington, upon "Arteriosclerosis."

Officers for 1912-13 were elected as follows: President, Dr. John E. Evans, Baltimore; First Vice-President, Dr. G. Latrobe Ewalt, Baltimore; Second Vice-President, Dr. George L. Wetzel, Carroll County; Corresponding Secretary, Dr. M. E. Shamer, Baltimore; Recording Secretary, Dr. P. B. Towler, Baltimore; Treasurer, Dr. A. J. Davies, Baltimore; Librarian, Dr. Charles A. Fetterhoff, Baltimore; Board of Censors, Drs. L. R. Palmer, Harry G. Jones and H. H. Stansbury; Board of Medical Examiners, Drs. G. H. Wright, O. N. Duvall, H. H. Stansbury, M. E. Shamer, W. D. Thomas, C. F. Goodell, A. P. Stauffer and L. R. Palmer; Delegates to A. I. H., Pittsburgh meeting, Dr. E. C. Price, C. S. Rumsey, H. H. Stanbury and H. M. Stevenson; Legislative and Auditing Committee, Drs. L. R. Palmer, H. M. Stevenson, M. B. Hood and Ira L. Fetterhoff.

Barrett Conner Catlin, M. D., Secy.



# THE HAHNEMANNIAN MONTHLY NEWS AND ADVERTISER

A Medical Newspaper

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JUNE, 1912

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**Modern Urinology.**—A System of Urine Analysis and Diagnosis. Illustrated. By Clifford Mitchell, A. B., M. D., Professor of Chemistry, Clinical Urinology and Renal Diseases, Hahnemann Medical College, Chicago, Ill. 636 pages. Cloth, \$3.00 net. Postage, 27 cents. Philadelphia. Boericke & Tafel, 1912.

In the publication of the volume now before us, Dr. Mitchell has made a valuable contribution to medical literature and the homœopathic school can well be proud of the fact that one of its members has written what is probably the most complete and most practical work on the subject of urine analysis now before the medical profession.

The scope of the work is most comprehensive and can be best indicated by giving the titles of some of the more important chapters.

Chapter I deals with the chemical composition and physical characteristics of the urine.

Chapters 3 and 4 with the acidity and specific gravity, the total solids, etc.

Chapters 6 to 26 deal with the various organic and inorganic substances found in the urine and the qualitative and quantitative tests for determining their composition.

Chapters 26, 27, 28 and 29 take up the subject of microscopic examination of the urine including the various inorganic substances, casts, connective tissue, seminal fluid, micro-organisms, parasites, etc.

Chapter 30 deals with the determination of the renal function. Chapter 32 with the detection of drugs and poisons in the urine.

Chapter 34 contains a concise resumé of the urinary findings in a large number of diseases in which the urine analysis is of special importance.

While Dr. Mitchell has presented his information in language that is plain and easily understood and while the work is of an eminently practical character and adapted for the use of the general practitioner, it must not be supposed that the ground is covered in any superficial manner. As a matter of fact, every phase of the subject is dealt with completely and thoroughly and the work will meet the needs of surgeons, internes and specialists in every respect.

Aside from its scientific merits, the illustrations and the general typography of the work are worthy of special mention.

**Diseases of the Genito-Urinary Organs and the Kidney.** Third Revised Edition. Diseases of the Genito-Urinary Organs and the Kidney. By Robert H. Greene, M. D., Professor of Genito-Urinary Surgery at the Fordham University, New York; and Harlow Brooks, M. D., Assistant Professor of Clinical Medicine, University and Bellevue Medical College. Third Revised Edition. Octavo of 639 pages, 339 illustrations. Philadelphia and London: W. B. Saunders Company, 1912. Cloth, \$5.00 net; half morocco, \$6.50 net.

The fact that this work has reached a third edition in a comparatively short time indicates that the authors have succeeded in producing a book that has proven of direct utility to the medical profession. The popularity of the work may, to an extent be accounted for by the fact that it is the conjoint product of a surgeon and a physician, and equal attention has been paid to both the medical and surgical aspects of the diseases under consideration. The scope of the work, as the title indicates, covers the diseases of the urinary and genital organs, but we note that the larger amount of space has been devoted to the urinary organs proper.

After taking up the general examination of patients and the uses of the cystoscope and other instruments for examining the genito-urinary organs, the authors next proceed to give a concise resumé of the important facts of urine analysis.

The diseases of the kidneys are then taken up seriatim, followed by chapters on diseases of the bladder, of the urethra, prostate and testicles.

In the present edition much new matter has been added to the work and it can be relied upon as being a thoroughly up-to-date and authoritative treatise on the subject of genito-urinary diseases.

**Autobiography of a Baby.**—By Thomas Lindsley Bradford, M. D., Philadelphia, Pa. David McKay, Publishers, 604 South Washington Square, Philadelphia. Price, 50 cents.

This little volume was written for the purpose of giving, in the form of a story, such information as mothers need in caring for the baby. It is at once entertaining, instructive and practical.

**Operative Obstetrics, Including the Surgery of the New-Born.** By Edward P. Davis, A. M., M. D., Professor of Obstetrics Jefferson Medical College, etc., etc., with two hundred and sixty-four illustrations. Philadelphia and London: W. B. Saunders Company.

The recent development of obstetric surgery has reached a point where a concise statement of the methods of operating in obstetrics would be of service to the profession.

Dr. Davis has endeavored to supply this demand in the volume now before us. The work is divided into four parts. Part one deals with the surgery of pregnancy and includes such conditions as uterine displacements, the removal of uterine tumors during pregnancy, operations upon the Fallopian tubes and ovaries, perineum, etc. Part two deals with the surgery of labor covering the manual extraction of the fetus by forceps, version, delivery by abdominal section and rupture of the uterus.

Part three takes up the surgery of the puerperal period including the removal of the placenta, the control of hemorrhage during labor and after labor, correction of the uterine displacements following labor, surgery of septic infection and puerperal mastitis.

Part four covers the surgery of the new-born including sections dealing with hernia, surgical treatment of fractures in the new-born, injuries to the skull, surgical treatment of infection in the new-born.

The work is profusely illustrated and the general typography and make-up of the book is worthy of special commendation. It is a work which should prove of great value to the obstetrician and to the general medical practitioner.

**A Manual of Surgical Treatment.**—By Sir W. Watson Cheyne, Bart., C. B., D. Sc., LL. D., F. R. C. S., F. R. S., Hon. Surgeon in Ordinary to H. M. the King; Senior Surgeon to King's College Hospital, and F. F. Burghard, M. S. (Lond.), F. R. C. S., Surgeon to King's College Hospital, and Senior Surgeon to The Children's Hospital, Paddington Green, London. New (2d) edition. Thoroughly revised and largely rewritten. In five volumes, containing about 3,000 pages and illustrated with about 900 engravings. Price, cloth, \$6.00 net, per volume. Lea & Febiger, Publishers, Philadelphia and New York, 1912.

The publication of the second volume of this invaluable work in little over a month after the appearance of the first is indicative of the systematic and energetic work of its editors and contributors. This rapidity in the appearance of the successive volumes ensures to the purchaser a complete and modern library of surgical treatment, equally fresh and up-to-date throughout. This volume covers the surgical affections of the skin and subcutaneous tissues, of the nails, lymphatic vessels and glands, fasciae, bursae, muscles, tendon sheaths, tendons, nerves, veins and arteries, as well as the surgical treatment of special aneurysms; the consideration of surgical affections of the bones follows, including fractures and the various diseases which require surgical intervention; and the volume closes with a discussion of amputations.



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## Homœopathic Medical Society *of the* State of Pennsylvania

*Annual Meeting*  
DELAWARE WATER  
GAP :: September  
17, 18 and 19, 1912

**The Care of the Insane and Hospital Management.** By Charles Whitney Price, M. D. 154 pages. Price, prepaid, \$1.00. W. M. Leonard, Publisher, Boston.

In this little volume of 155 pages the author presents the results of his experience of thirty-five years' service as a medical officer in hospitals for the insane. The author devotes considerable space to the internal workings of hospitals where "non-restraint" is the practice in dealing with insane patients. It is a work which is well worthy of serious consideration.

W. B. Saunders Company have just issued a new (16th) edition of their Illustrated Catalogue which describes some forty new books and new editions published by them since the issuance of the former edition. The books listed in this catalogue cover every subject of interest to the medical man. The descriptions and illustrations are such as to enable the reader to select easily just the book he wishes on any branch. It is really an index to correct medical literature—an index by which the practitioner, the surgeon, and the specialist can acquaint himself with what is new in the literature of his subject.

This edition also contains an illustration and description of Saunders' new building, now being erected on Washington Square, Philadelphia's new publishing centre. Any physician wishing a copy of this handsome catalogue can obtain one free by addressing W. B. Saunders Company, 925 Walnut street, Philadelphia.

**Physiology.**—A Manual for Students and Practitioners. By A. E. Guenther, Ph. D., Professor of Physiology in the University of Nebraska, and Theodore C. Guenther, M. D., Attending Physician, Norwegian Hospital, Brooklyn, N. Y. New (second) edition, thoroughly revised. 12mo, 269 pages, illustrated. Cloth, \$1.00, net. The Medical Epitome Series. Lea & Febiger, Publishers, Philadelphia and New York, 1912.

The continued demand which has absorbed several printings of the first issue of this work, and has now led to the publication of a new edition, is a fair indication that it has accomplished the object for which it was created. Its purpose is to furnish the student and practitioner a brief exposition of physiology as a means of quickly reviewing the essential features of the subject. In this new edition both text and illustrations have been subjected to searching revision.

**Pituitrin in Difficult Parturition.** Much attention is being given by the medical press of Germany and other European countries to the importance of Pituitrin as an oxytocic. The drug has been somewhat extensively used for the past two or three years, both here and abroad, chiefly, perhaps, as a hemostatic and heart stimulant. Now it is known to be of great value in uterine inertia, obstetricians in many of the German hospitals and elsewhere who have thoroughly tested it clinically, pronouncing it a truly remarkable oxytocic.

For the benefit of practitioners who may not be familiar with its origin and nature, it may be explained that Pituitrin is an extract of the posterior or infundibular portion of the pituitary gland. Although the physiology of this gland is as yet largely speculative, there seems to be no doubt that it contains a substance or substances that exert a considerable influence over the metabolism and on the cardio-vascular system.

As bearing upon the value of Pituitrin in parturition, this expression from Dr. Emil Vogt, of the Royal Gynecological Clinic at Dresden, is significant:

"The oxytocic action of Pituitrin at this clinic was observed in over one hundred cases. After the rupture of the fetal membranes, in the second stage of labor, the physiologic effect of Pituitrin is the most pronounced; the contractions of the uterus follow each other much more rapidly and energetically, and the intervals between pains are decreased. Individually the pains are not more severe, so far as suffering is concerned, even in the case of sensitive women, than they would be in a normal delivery. In half of the cases the Pituitrin was administered in the second stage of labor. It failed only once; in all other instances its action was very pronounced. And although we encounter a great many cases of narrow pelvis in Dresden, from 40 to 50 per cent., it was not necessary to have recourse to forceps delivery in a single instance in which Pituitrin was employed. . . . According to our experience, Pituitrin is the ideal oxytocic."

Pituitrin is manufactured by Parke, Davis & Company. It is supplied in one-ounce bottles and in glaseptic ampoules (for convenience hypodermic injection), each ampoule containing one cubic centimeter, or 16 minims., the usual dose.

Parke, Davis & Company have just issued a pamphlet on Pituitrin as an oxytocic, in which is reprinted not only the extract from Dr. Vogt which appears in this article, but also a number of others from prominent German specialists and practitioners in which Pituitrin is highly extolled as a corrective of uterine inertia. Physicians will do well to write the company, addressing them at the home office in Detroit, for a copy of the pamphlet.

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#### COMMENCEMENT EXERCISES.

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##### Hahnemann Medical College of Philadelphia, Pa.

The Annual Commencement of the Hahnemann Medical College of Philadelphia, was held in the Academy of Music on Thursday, June 6th, at 12 M. Thirty-five students received diplomas. Charles D. Barney, President of the Board of Trustees of the College, conferred the degrees of Doctor of Medicine and Doctor of Homœopathic Medicine upon the members of the class, and the Dean of the College, Dr. William B. Van Lennep, announced the names of the prize winners.

Mr. Woodruff told the graduates of the statement made at a meeting of the School Hygiene Association of New York, to the effect that the physician of the future would serve less and less in the capacity of a family doctor; that he would become more and more a community doctor, and would sacrifice studying and curing individual diseases to teaching the laws of hygiene and preventative medicine. He said this theory was nothing more nor less than the old adage that an ounce of prevention is worth a pound of cure, but that this is an age when greater emphasis is being placed upon society than upon the individual.

Mr. Woodruff said we now had a sight of that kind of medical work in the medical inspector in the schools, the health officer, the city bacteriologist, and in the lengthened list of food and health inspectors. He declared it a sign of the times that for the first time the Conference of Charities and Correction would discuss the relation of medical and social work.



"The physician of the coming day," he said, "who will most completely meet the highest ideals of his profession will be he who embodies Bishop Brooks' significant statement that no man can come to true greatness who does not realize that he belongs to the whole race."

#### **The Graduates.**

The graduates were: Norman Hallowell Bassett, Swarthmore, Pa.; Conrad Cullis Bell, Kingston, Jamaica; James Bebout Bert, Beaver Falls, Pa.; William Johnston Books, Danville, Pa.; Carey Clarence Bradin, Tyrone, Pa.; Thomas Irving Cottom, Uniontown, Pa.; Earle La Mont Creveling, Jersey City, N. J.; Edward Everett Dowdle, Alameda, Cal.; Thomas Perrine Edmundson, Pittsburgh; Joseph Mark Ellenberger, Annville, Pa.; John Lee Fisher, Wilmington, Del.; Alvin George Koehler, Plymouth, Wis.; Eric Victor Light, Annville, Pa.; Harry Oliver Mateer, Pittsburgh; Samuel Henry Pettler, Beaver Falls, Pa.; Edward Alexander Pitcairn, Pittsburgh; Francis Michael Quinn, Minersville, Pa.; Samuel Miles Robinson, Somerville, N. J.; James Guie Spackman, Coatesville, Pa.; Elmer Herbert Stumpf, Buffalo; F. Donaldson Thomas, Forty Fort, Pa.; William Wayne Wickersham, Coatesville, Pa. The following from Philadelphia: Leon Clemmer, Andrew Flanagan, Jr., Charles Joseph Valentine Fries, Jr., Theodore Kennedy Gramm, B. A. Harry Hathaway, Howard Frederick Heinkel, Charles Biddle Hollis, John Louis Metzger, Jr., Walter Nelson Norley, Benners Simpson Smith, Joseph Augustus Stegmenn, Jr., Bernard Girard Walker and Walter Louis Woerner.

#### **Prizes and Scholarships.**

The prizes and scholarships awarded were as follows: Scholastic prizes of \$75, \$50 and \$25, offered by the trustees to members of the graduating class attaining the first, second and third highest general averages. First prize, Leon Clemmer; second prize, Earle La Mont Creveling; third prize, Harry Oliver Mateer.

Prize in *Materia Medica*, Clarke's Dictionary of *Materia Medica*.—Earle La Mont Creveling. Honorable mention, Leon Clemmer.

Prize in *Medicine*, Blood Pressure Apparatus.—Earle La Mont Creveling. Honorable mention, Leon Clemmer.

Prize in *Surgery*, \$25.—Leon Clemmer. Honorable mention, Thomas Irving Cottom.

Prize in *Gynaecology and Obstetrics*, the John E. James Memorial Prize, \$25.—Alvin George Koehler. Honorable mention, Leon Clemmer.

Prize in *Laryngology, Ophthalmology and Otology*, \$25.—Leon Clemmer. Honorable mention, Conrad Cullis Bell.

Prize in *Neurology*, \$25.—Earle La Mont Creveling. Honorable mention, Thomas Perrine Edmundson.

Prize in *Pathology*, \$25.—Daniel Edward Lawrence Stedem. Honorable mention, Edgar Maul Blew and Harry L. Shaffer.

Prize in *Chemistry, Urinalysis Set*.—William Lemmon Martin.

Prize in *Histology*, \$25.—William Lemmon Martin. Honorable mention, Alfred Dirsch Stickler.

The President's Scholarship.—Elwood Emerson Downs. Honorable mention, W. Arthur Schmitz, Philip J. Lewert.

The Walter E. Hering Scholarship.—Harry L. Shaffer. Honorable mention, Edgar Maul Blew, Hugh Ryan.

The Pittsburgh Alumni Scholarship.—Harry Dellmarr Conley. Honorable mention, Harold P. Peckham, William Lemmon Martin.

The graduation exercises at Hahnemann College were followed by reunions of the members of the classes of 1882, 1887, 1892, 1897, 1902 and 1907 in the Bellevue-Stratford. At these reunions the newly graduated doctors were made members of the Alumni Association.

**The Clinico-Pathologic Society.** The Clinico-Pathologic Society held its regular monthly meeting at the Hahnemann College on Saturday evening, May 18th. The following papers were presented: "The Necessity of the General Practitioner," Joseph C. Guernsey, M. D.; "A Report of Results of Salvarsan in Fifty-two Cases," J. M. Kenworthy, M. D. These papers were of considerable interest and were well discussed.

**Nurses Commencement.** The Fifteenth Annual Commencement of the Training School for Nurses of the Homœopathic Medical and Surgical Hospital of Reading, Pa., was held on Thursday evening, May 23, 1912, in St. Paul's Memorial Reformed Church. The diplomas were presented by Mr. C. H. Ruhl, President of the Board of Trustees. Addresses were made by Dr. G. Harlan Wells of Philadelphia, and John M. Frame, Esq.

**The Indiana Institute of Homœopathy** held its Forty-sixth Annual Session at the Claypool Hotel, Indianapolis, on May 21 and 22, 1912. A very large and practical scientific program was presented. On Tuesday, May 21st, the members were entertained at a banquet given by the Marion County Homœopathic Medical Society.

**The Annual Meeting of the West Jersey Homœopathic Medical Society** was held in the parlor of the West Jersey Homœopathic Hospital in Camden, on Wednesday, May 15th. Drs. Howard, McGeorge and Hadley related some echoes from the State Society which held a three days' session during the week just preceding. Dr. L. T. Ashcraft gave "A Stero Clinic, Illustrating the Treatment of the Urinary Bladder by Fulguration." Dr. E. S. Sheldon of Collingswood, was elected President; Dr. W. T. Hilliard, of Salem, Vice-President; Dr. T. E. Parker, of Woodbury, Secretary, and Dr. S. Bryan Smith, of Merchantville, Treasurer.

**The Homœopathic Medical Society of the State of Ohio** held its Forty-Eighth Annual Session at the Hotel Algonquin, Dayton, Ohio, May 14 and 15, 1912. Quite a number of interesting papers were presented and a number of the leading homœopathic practitioners in the middle west were present.

**The American Institute of Homœopathy** will hold its Sixty-Eighth Annual Meeting at the Soldiers' Memorial Hall, Pittsburgh, Pa., June 16 to 22, 1912. The following hotels have promised first-class service at given rates: Hotel Schenley, Fifth avenue, near Memorial Hall, (European plan) \$2.00 to \$3.00 per day; Fort Pitt Hotel, Penn avenue and Tenth street, two blocks from Union Station (European plan) \$1.50 to \$2.50 per day; Hotel Lincoln, Penn avenue near Fifth street (European plan) \$1.50 to \$2.00 per day; Hotel Henry, Fifth avenue near

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Smithfield street (European plan) \$1.50 to \$2.00 per day; Seventh Avenue Hotel, Seventh avenue and Liberty avenue (European and American plans) \$1.50 to \$3.50 per day; Monongahela House, Smithfield and Water streets, near B. & O. Depot (European plan) \$1.00 to \$2.00 per day; Hotel Duquesne, Smithfield street near Fifth avenue (European plan) \$1.00 to \$2.50 per day; Hotel Anderson, Penn avenue and Sixth street (European plan) \$1.00 to \$2.50 per day; Hotel Kenmawr, Shady avenue and Howe street (European plan) \$3.50 per day; Swearingen Hotel, Craig street near Fifth avenue (American plan) \$2.50 per day.

Members from the East coming on the Pennsylvania Railroad and intending to stop at either the Schenley, Kenmawr or Swearingen Hotels, will leave their train at East Liberty Station. Street cars run directly from there.

### **Social Features.**

The Entertainment Committee of which Dr. William Alvah Steward, of Pittsburgh, is Chairman, has prepared a number of interesting features. Beginning with Sunday afternoon there will be an organ recital at Carnegie Music Hall which will begin at 4 o'clock.

A number of trips have been prepared for Wednesday afternoon including an automobile tour of the parks and boulevards which will start from the Hotel Schenley at 3.30.

Cards will be issued to members of the Institute giving them the privileges of the Pittsburgh Athletic Club and the University Club during their stay in the city. The club houses are located just across the street from Memorial Hall. A number of smokers, dinners and other social gatherings have been planned, most of which will take place on Wednesday evening, after the scientific session of the Institute has adjourned.

On Friday evening a banquet will be tendered the members of the Institute by the Allegheny County Homœopathic Medical Society. The Institute Fraternity, the Phi Alpha Gamma Fraternity, and the Alpha Sigma Fraternity are all preparing to hold business and social meetings during the week.

### **Amendments.**

The following amendments were proposed at the meeting of the Institute held at Narragansett Pier, June 25-July 1, 1911, thus complying with the requirements of the by-laws, which make necessary one year's notice of proposed amendments:

Article VII, Section 1. Add the following. (h) The Press Committee, (j) The Committee on Transportation.

Section 2. Add the following:

The Press Committee (h) shall consist of three members, one to be appointed for three years, one for two years, and one for one year, respectively, and thereafter one member to be appointed each year to serve for three years.

The Transportation Committee (j) shall consist of three members, to be appointed, one for three years, one for two years, and one for one year, respectively, and thereafter one member to be appointed each year to serve for three years.

Section 3. Amend by striking out the words "within thirty days after his election announce" and inserting the words "on September 26th,

the day of his inauguration, forward to the secretary the names of," so that the section will read as follows:

Article VII, Section 3. The President shall, on September 26th, the day of his inauguration, forward to the Secretary the names of the chairmen of bureaux and the standing committees not otherwise provided for, who shall serve during his administration.

Article VI, Section 1. Add the following: (f) The Bureau of Dermatology and Genito-Urinary Diseases.

Article V, Section 5. Following the words "annual dues," third line of the paragraph, insert the words "after reaching the age of seventy years," so that this part of the paragraph shall read, "All members of the Institute who have maintained twenty-five consecutive years' membership in the American Institute of Homœopathy unincorporated shall be considered senior members and be exempt from annual dues after reaching the age of seventy years, \* \* \* ."

Article X, Section 8. Omit paragraph, "Upon declaration of the result, should no election be had for any office, the Institute shall elect from two candidates receiving the highest number of votes, which person it prefers." Substitute for this the paragraph, "The candidate receiving the highest number of votes shall be declared elected to office."

The following program has been prepared:

#### **Sunday.**

Memorial Exercises. Dr. James C. Wood will address the Institute, and Dr. Edward Harper will announce the names of "Our Absent Members."

#### **Monday.**

From 9 to 10.30, "Institute Business;" 10.30 to 1 P. M., "Bureau of Materia Medica;" 2.30 to 6 P. M., "Bureaus of Materia Medica," "Obstetrics," "Dermatology," "O. O. & L. Society;" 8 to 10 P. M., "Opening Exercises," followed by reception at Hotel Schenley.

#### **Tuesday.**

9 to 10.30 A. M., "Institute Business;" 10.30 A. M. to 1 P. M., "Bureau of Homœopathy;" 2.30 to 6 P. M., "Bureaus of Homœopathy, Obstetrics, Neurology, O. O. & L. Society;" 8 to 10 P. M., "Bureaus of Homœopathy, Materia Medica, Obstetrics, O. O. & L. Society."

#### **Wednesday.**

9 to 10.30 A. M., "Institute Business;" 10.30 A. M. to 1 P. M., "Bureau of Clinical Medicine;" 2.30 to 6 P. M., "Entertainment;" 8 to 10 P. M., "Bureaus of Clinical Medicine, Surgical and Gynecological Society, O. O. & L. Society."

#### **Thursday.**

9 to 10.30, "Institute Business;" 10.30 A. M. to 1 P. M., "Surgical and Gynecological Society;" 2.30 to 6 P. M., "Bureau of Clinical Medicine, Surgical and Gynecological Society, Physical Therapeutic Society, O. O. & L. Society;" 8 to 10 P. M., "Surgical and Gynecological Society, Physical Therapeutic Society, O. O. & L. Society."

**Friday.**

9 to 10.30 A. M., "Institute Business;" 10.30 A. M. to 1 P. M., "Bureaus of Pedology and Sanitary Science;" 2.30 to 6 P. M., "Bureaus of Pedology and Sanitary Science;" 2.30 to 6 P. M., "Bureaus of Pedology and Sanitary Science, Physical Therapeutic Society, O. O. & L. Society;" 8 to 10 P. M., "Banquet."

**Saturday.**

9 to 10.30 A. M., "Institute Business."

**To Members of the Institute.** The Transportation Committee has decided to utilize the Pennsylvania lines both from New York and Chicago. We have obtained a rate of one fare and three-fifths on the Trunk Lines Association, which means the territory east of Buffalo and Pittsburgh, west of the Hudson River, north of the Potomac River and south of the Canadian line, also New England Passenger Association, which includes all of New England.

This is on the certificate plan and all members asking for a certificate as they buy their ticket, can avail themselves of this rate. Remember, that a receipt is not a certificate. On previous occasions people who have gotten a receipt for their ticket have not been able to take advantage of the rate, due to the fact that a receipt is not recognized by a railway.

Dr. J. B. Garrison, Suite 26, 618 Madison Ave., New York, will take charge of the eastern end and make the arrangements for the New York and eastern routes. From Chicago we propose to leave Saturday, July 15th, at 8 P. M. Special cars will be placed on that train to take care of the people going from Chicago to Pittsburgh. I hope all who go through Chicago to Pittsburgh will take advantage of this so that we can all go together. The train reaches Pittsburgh at 9.25 Sunday morning, which is a nice hour with a minimum loss of time from office hours and other things, giving us plenty of time in Pittsburgh to arrange ourselves so we can attend the evening meeting. Those who have summer tourist rates reading beyond Pittsburgh will be obliged to take the train at 5.30 or one earlier in the day, as the 8 o'clock train will not honor tickets beyond Pittsburgh, but all other tickets from whatever point going as far as Pittsburgh only, will be honored on that train.

The fare from Chicago will be \$10.50 one way, or \$20.00 round trip. This is practically on a two cent basis. The Central Passenger Association have refused any special convention rates this year due to the fact that the Interstate Commerce Committee is, at the present, considering the question of further reductions on their lines. We have had no communication or report from the Trans-Continental Association, but we hope that we may be included in whatever rates are made.

First class up-to-date sleepers will be provided and if a sufficient number go through from Chicago, a special train will be provided to follow the 8 o'clock train immediately after it leaves. We feel that there is an advantage in going on our own cars, as it gives the new members an opportunity of becoming acquainted with the older ones, at the same time, assuring us the best equipment and the newest up-to-date cars. Those beyond Chicago from the south or west who are to take advantage of the train going with the crowd, can have accommodations reserved for them by addressing the Chairman of the Committee, T. E. Costain, M. D., Chicago, Ill.



# THE HAHNEMANNIAN MONTHLY NEWS AND ADVERTISER

A Medical Newspaper

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JULY, 1912

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**Psychotherapy**, including the history of the Use of Mental Influence, Directly and Indirectly, in Healing and in the Principles for the Application of Energies Derived from the Mind and the Treatment of Diseases. By James J. Walsh, M. D., Ph. D., Dean and Professor of Nervous Diseases at Fordham University, N. Y. 740 pages, Illustrated. Cloth, \$6.00 net. D. Appleton & Company.

Many books on the use of the mind to influence the body have been written in recent years, but these have concerned mainly the therapeutics of functional nervous disease. Dr. Walsh has done something different. He has taken the whole field of medicine, organic as well as functional disease, somatic and nervous, and has shown the application of mental influence in the treatment of these affections. The chapters in special therapeutics in which disease or set of diseases is taken and the suggestions proper for each outlined make the book eminently prac-

tical. The author is not a therapeutic nihilist. He is no skeptic of the power of surgery, and he has strong convictions on the necessity of drugs properly administered. He points out, however, numerous instances where supposed drug efficacy is due to mental influence. The book is written not for the psychiatrist and neurologist but for the general practitioner, and it should prove of the utmost value in every-day practice.

**Progressive Medicine.**—A Quarterly Digest of Advances, Discoveries and Improvements in the Medical and Surgical Sciences. Edited by Hobart Amory Hare, M. D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia, etc., assisted by Leighton F. Appleman, M. D., Instructor in Therapeutics, Jefferson Medical College, Philadelphia, etc. Volume II. June, 1912. Lea & Febiger, Philadelphia and New York, 1912. Price, \$6.00 a year.

The present volume of *Progressive Medicine* is devoted to Surgery of the Abdomen, Gynecological Diseases, Diseases of Nutrition and of the Glandular System, and Ophthalmology.

It is difficult to select from the amount of useful information contained in this volume, the sections that would be of most value to the medical practitioner.

In the section devoted to surgery, a great deal of space is given to the surgery of the stomach and a very thorough review is presented of the revolutionary steps that have been made in the surgery of the stomach during the past few years.

Dr. Stengel has covered very carefully the subject of Diseases of Blood and the amount of information that he has gathered together relating to leukemia, pernicious anemia, hemophilia, etc., will be of the greatest value to physicians desiring information along these lines.

The suggestions that are presented regarding the dietetic treatment of diabetes mellitus are also very important.

Dr. John G. Clark has presented the recent advances in gynecology in his usual thorough and able manner and those interested in this department of medical work will find much of value in this section.

One of the chief points of merit about "*Progressive Medicine*" is the fact that it appeals to all classes of physicians, no matter whether they are specialists or engaged in general medical work. It offers an opportunity for keeping abreast with the most recent developments in medical science with a minimum expenditure of time and money.

**Common Disorders and Diseases of Childhood.**—By George Frederic Still, M. A., M. D. (Cantab.), F. R. C. P. (Lond.) Professor of Diseases of Children, King's College, London, etc. Second edition. London, Henry Frowde. Oxford University Press, Warwick Square, E. C.

The volume now before us differs from the regular text-book in view of the fact that the writer has adopted a rather discursive style and has treated particularly the everyday and common place disorders that are most commonly met with in the routine of medical practice.

Throughout the work he has presented chiefly the clinical aspects of disease, particularly diagnosis and treatment, with such remarks on

pathology or morbid anatomy, as have a direct bearing upon the clinical management of the case.

Despite the fact that the author has not held himself down to any systematic consideration of subjects in their usual order, he has, nevertheless, covered very thoroughly all of the diseases of childhood that are met with with any degree of frequency.

We are impressed with the practical nature of the information presented and with the fact that suggestions in regard to treatment are presented with much more detail than is usually found in a work of this character.

The work is a most admirable one and can be most favorably recommended as a practical guide to the physician desiring the latest information in this department of medical work.

**Salvarsan in Syphilis and Allied Diseases.**—By J. E. R. McDonagh, F. R. C. S. Surgeon to out-patients, London Lock Hospitals. London, Henry Frowde. Oxford University Press, Warwick Square, E. C., 1912.

This volume is of the nature of a supplement to "A System of Syphilis," recently published under the editorship of Power & Murphy, and is intended to describe salvarsan, its methods of use and the results that may be obtained from its administration.

The author has covered the ground very thoroughly and he has avoided that elaborate detail which detracts from the practical value of so many works of this character. The entire subject is contained in 150 pages. Some of the more important chapters are as follows: "Contra-Indications," "Methods of Administration," "Primary, Secondary and Tertiary Stages" and "Syphilis of the Nervous System."

The author is thoroughly convinced that in salvarsan we have a remedy that will prove of the greatest value in controlling syphilis and numerous other diseases depending upon infection by microscopic parasites. The work can be highly recommended as a very complete and impartial statement of the present status of salvarsan in medical practice.

**An Index of Differential Diagnosis of Main Symptoms.**—By various writers. Edited by Herbert French, M. A., M. D. Oxon., F. R. C. P., London, Assistant Physician to Guy's Hospital, with sixteen colored plates and over two thousand illustrations in the text. New York, William Wood & Co. Price, \$8.00.

This book is a treatise on the differential diagnosis of all the main signs and symptoms of disease. It aims at being of practical utility to medical men whenever difficulty arises in deciding the precise cause of any symptom of which the patient may complain. It covers the whole ground of medicine, surgery, gynecology, ophthalmology, dermatology and neurology.

The work is divided into two parts. The first part, consisting of eight hundred and fifty pages, contains all of the various symptoms that occur in the body arranged alphabetically, and the various diseases that may give rise to these symptoms are set forth together with such information as will be of value to the physician in arriving at a differential diagnosis.

The second section of the work, consisting of approximately one hundred and sixty-five pages, is a general index in which the symptoms are gathered together under the headings of the various diseases in which they occur.



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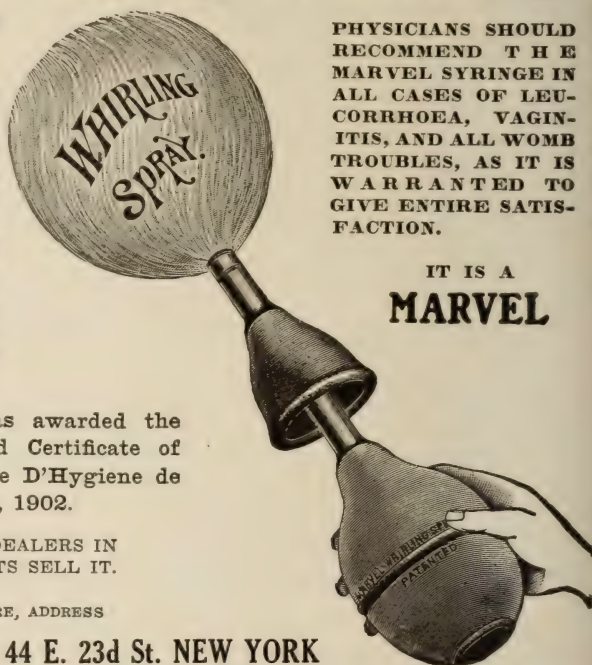
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#### HAHNEMANN COLLEGE NOTES.

**The Alumni Association** of the Hahnemann Medical College of Philadelphia, held its annual meeting in the College on Thursday, June 6th, at 3 P. M. The Annual Report of Dean was presented by Dr. William B. Van Lennep and great enthusiasm was expressed over the work that had been done during the past year.

It was ordered at the meeting that five thousand copies of this report should be published at the expense of the Alumni Association and distributed among the homœopathic physicians of the United States. The following officers were elected to serve during the ensuing year:

President—Dr. E. R. Gregg, Pittsburgh, Pa.

First Vice-President—Dr. A. W. Atkinson, Trenton, N. J.

Second Vice-President—Dr. Theo. J. Gramm, Philadelphia, Pa.

Third Vice-President—Dr. J. W. Pratt, Coatesville, Pa.

Treasurer—Dr. William H. Keim, Philadelphia, Pa.

Permanent Secretary—Dr. Edwin L. Nesbitt, Philadelphia, Pa.

Provisional Secretary—Dr. William V. Hunsicker, Philadelphia, Pa.

Executive Committee—W. D. Carter, '94; W. D. Culin, '94; J. D. Elliott, '01; J. A. Fischer, '95; F. D. Gilbert, '92; H. P. Leopold, '96; L. P. Posey, '83; A. W. Smith, '03; H. S. Weaver, '92.

**The Annual Banquet** of the Alumni Association of Hahnemann Medical College was held at the Bellevue-Stratford Hotel, at 6 P. M., on Thursday, June 6th. Dr. Lewis P. Posey acted as toastmaster. Toasts were responded to by Hon. Norris S. Barratt, Associate Judge of the Court of Common Pleas; Dr. William H. Keim, Class '71; Dr. Daniel P. Maddux, Class '83; Dr. Gilbert J. Palen, Class '95; Dr. W. F. Books, Class 1912. The occasion was a most successful one in every respect and was thoroughly enjoyed by the two hundred members and guests who participated in it.

**The Hay Fever Riddle.**—Despite the many therapeutic advances of recent years, "what to do for the hay fever patient" continues to be something of a puzzle. The long-sought specific still eludes us. Nevertheless, the malady is not quite the enigma that it once was. Medication, if still empiric, is not ineffective. The symptoms of the disorder can be controlled or minimized; relief, though temporary in many cases, may be obtained; and for these blessings the afflicted patient and the sympathetic physician may well be thankful.

For use in the treatment of hay fever there is, of course, a long line of so-called available medicaments. One dependable agent which comes naturally to mind in this connection is Adrenalin. Indeed, it is doubtful if any other single medicinal substance has been so largely and successfully employed in the treatment of vasomotor rhinitis. As adapted to the needs of the hay fever sufferer the product is available in a number of convenient forms, as Adrenalin Chloride Solution, Adrenalin Inhalent, Anesthone Cream, Anesthone Inhalent, Anesthone Tape, etc. The various solutions are used in spraying the nares and pharynx, the cream for snuffing into the nostrils, the tape for packing the nostrils. All cases of hay fever, of course, are not amenable to the same form of treatment.

It is a logical presumption, however, that a vast majority of them ought to yield to one or more of the preparations above referred to. The Adrenalin products, as is well-known to most physicians, are manufactured by Parke, Davis & Co., who will doubtless be glad to send literature regarding them to any practitioner. Requests for printed matter may be addressed to the company at its main offices and laboratories in Detroit, Mich.

**After the Baby Comes.**—The weakness and debility which usually follow childbirth are all too prone to linger. The burden of lactation is very apt to further prolong convalescence and increase the liability to all manner of complications. In such cases, vigorous tonic treatment is urgently required and the resulting reinforcement of vital processes promptly changes the situation.

Gray's Glycerine Tonic Comp. is peculiarly serviceable as a reconstructive and restorative for the nursing mother, not only because of its notable efficacy in promoting functional activity throughout the body, but especially because of its freedom from all contraindications. Thus it can be freely administered both during pregnancy and thereafter without a fear of its producing any but the most substantial benefits to the offspring as well as to the mother. Few remedies are more effective for increasing the lacteal flow than "Gray's," inasmuch as it exerts its influence through improving the whole bodily nutrition rather than by stimulating a single function at the expense of the rest of the body.

**The 68th Annual Session of the American Institute of Homœopathy** was held in the Soldiers' Memorial Hall, Pittsburgh, Pa., June 16 to 22, 1912. The memorial exercises were held on Sunday evening, June 16th, in honor of the members who passed away since the last meeting of the Institute. Dr. James C. Wood of Cleveland, delivered an address on the composite physician. The Necrologist announced the names of the following members who have died since the 1911 meeting:

Henry C. Angell, M. D.	Walter Joel King, M. D.
Harry H. Baker, M. D.	Eliza Lang McClure, M. D.
William Cullen Bryant, M. D.	Thomas Graham McConkey, M. D.
Isaac Buckeridge, M. D.	Ada B. Morgan, M. D.
Merritt B. Campbell, M. D.	Gustave A. Mueller, M. D.
Whitman E. Clark, M. D.	J. Lawrence Nevin, M. D.
Carl Crisand, M. D.	Hugh Pitcairn, M. D.
Frank M. Cummins, M. D.	Joseph Robert Pollock, M. D.
Alicia A. Flanders, M. D.	Harlan Pomeroy, M. D.
James Eldridge Gross, M. D.	Emmor H. Price, M. D.
Charles H. Gundelach, M. D.	John W. Primm, M. D.
Joseph Hensley, M. D.	William Fritchey Roth, M. D.
Eugene A. Hults, M. D.	William H. Somerville, M. D.
Otis M. Humphreys, M. D.	John Wesley Watenpaugh, M. D.
Maurice P. Hunt, M. D.	Edith C. Wells, M. D.
Amanda H. Kempton, M. D.	Charles B. Wurtz, M. D.

The first session was called to order at 9 A. M., Monday, by President Thomas H. Carmichael of Philadelphia, who delivered a preliminary address. The business of the Institute was then taken up and the reports of the standing committees were made. On motion, a special committee consisting of Dr. George S. Royal, Dr. J. H. Mc-



Clelland, Dr. J. P. Sutherland, Dr. R. S. Copeland, Dr. J. P. Gregg Custis, was appointed to confer with a committee representing the American Medical Association regarding the establishment of a national bureau of health. Following this the nomination of officers for the ensuing year took place and the meeting adjourned.

At 8 P. M. the opening exercises of the Institute were held in Memorial Hall in the presence of a large assemblage composed of members of the Institute and their guests and the citizens of Pittsburgh. Dr. J. H. McClelland of Pittsburgh, presided and a number of stirring addresses were made, but the annual presidential address of Dr. Thomas H. Carmichael was the feature of the evening. Dr. Carmichael's address touched upon the relationship existing between the homœopathic and other schools of medical practice and was a forceful appeal for medical unity along broad and liberal lines. Following these exercises a reception and ball were held in the Hotel Schenley. On this occasion several hundred physicians and members of their families were present, and the occasion was a most enjoyable one.

A number of important matters were brought before the Institute this year that will have an important influence on the future of homœopathy. Probably the most important subject discussed was the nation-wide campaign to raise a fund of one million dollars for the purpose of popularizing homœopathy. Dr. W. H. Diffenbach of New York, outlined a plan whereby this money could be raised and about four thousand dollars were pledged by the members present at the meeting.

It was planned to appoint a committee of one hundred and sixty members from various parts of the United States to carry on this work. It was suggested that each member be requested to give to the fund his income for one day of each year. The day designated being April 10th, the birthday of Hahnemann.

Another matter of vital importance was the conference of a committee of the Institute with a committee of the American Medical Association regarding the creation of a Federal Bureau of Health. After careful consideration of the matter a compromise was reached between the two committees which above schools are pledged to support in order to secure governmental supervision of health and sanitation. The election of officers for the ensuing year resulted as follows:

President.—W. B. Hinsdall, Ann Arbor, Mich.

Vice-Presidents.—Dr. B. Stout, Jacksonville, Fla., and Dr. Mary E. Banks, Chicago, Ill.

Treasurer.—Dr. T. Franklin Smith, New York.

Secretary.—Dr. J. Richey Horner, Cleveland, O.

Register.—Dr. W. O. Forbes, Hot Springs, Ark.

It was agreed to hold the next Annual Meeting of the Institute at Denver, Col.

No report of the meeting would be complete without reference to the delightful manner in which the members were entertained by the homœopathic profession of Pittsburgh and vicinity. The provisions made for the meeting of the Institute and its various bureaus and affiliated societies were very satisfactory and the accommodations at the hotels and clubs were all that could be desired.

Among the numerous social features were the reception and ball at the Hotel Schenley and the banquet on Friday evening, as well as the numerous smokers, dinners, etc., that were given at various times during

the week. All of these combined to make the occasion a most enjoyable one from a social standpoint.

**The Return from the Country.**—Almost every city family, whose exchequer will permit, is accustomed to spend a goodly portion of the heated term away from home. This is both natural and salutary, provided good judgment is exercised in the selection of the country place or summer resort, as regards its general healthfulness and sanitary environment. Unfortunately sanitation on farms and in rural communities is not always what it should be and the result is that many health and pleasure seekers return in the Autumn depressed and run down or perhaps infested with malarial or typhoidal poison. In other cases, especially at crowded fashionable resorts, because of the continual round of exciting amusements, some are tired and fagged out instead of rejuvenated as the result of their Summer's outing. Many are certainly in need of that general constitutional reconstruction and building up of force and resistance which is necessary to withstand the business or social strain of the fall and winter. In such cases there is no one single remedy quite as dependable as Pepto-Mangan (Gude). It increases appetite, restores strength and general vitality, reinforces the hemoglobin content of the blood and acts as a prompt and efficient general tonic and reconstituent for patients of all ages.

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#### PENNSYLVANIA STATE NOTES.

**The State Medical Society.**—Now that the meeting of The American Institute of Homœopathy has come to a successful close, naturally, all loyal Pennsylvania homœopaths will turn their attention and energies towards making the next meeting of "The State Medical Society" the best ever, which takes place at the Delaware Water Gap, "The Kittatinny" being the official headquarters.

There is no better way for Pennsylvania loyalists to show their enthusiasm for the cause than by assisting in producing new members for "The State Medical Society." Last year's unexceptional record of 135 new members for the State Society had previously been unequalled.

Pennsylvania as the Keystone State of the Union, naturally prides itself as being the Keystone State of homœopathy as well.

The membership committee is again actively at work in attempting to reach the record of new members obtained last year, and if at all possible, to do even better. The committee cannot succeed, however, without your assistance. If you are already a member of the State Society, and attend its meetings, you are doing nothing more than your duty. If you know of any of your colleagues who are not members of the State Society, it is just as much the part of your duty to see that they become members of the same.

The President, Dr. G. J. Palen, is striving hard for a successful meeting, and every indication goes to point that this year will be a banner one for Pennsylvania homœopaths.

You can show no better loyalty to the cause of homœopathy, your State Society, and your president than by assisting in the production of new members for "The Delaware Water Gap" meeting.

Dr. Palen is particularly anxious that our State Society should not go backwards in the production of new and active members. Let us strive

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in this direction, for the strength of any organization is measured by the numbers upon its membership list. Pennsylvania with its 700 members has never been equalled by any other State in the Union. Will you not assist in keeping up this enviable standard?

Forward membership blanks properly endorsed, with check for \$5.00 which includes everything for the first year, reminding you of the "Hahnemannian Monthly," which is now the official journal of "The State Medical Society." Then, for further information and additional membership blanks address the undersigned,

RALPH BERNSTEIN, Chairman,  
37 South Nineteenth Street,  
Philadelphia.

**Meeting of Hospital Trustees.** The annual meeting of the trustees of the Hospital Association of the Hahnemann Medical College and Hospital was held May 10, 1912, at the institution. John Gribbel was elected to fill the vacancy on the Board of Trustees caused by the death of James W. McAllister. Four other trustees whose terms expired May 1st, were re-elected. They were Rev. Floyd Tomkins, Ernest L. Tustin, Clarence Bartlett, M. D., and Louis P. Posey, M. D. The officers of the year will remain as at present: President, Charles D. Barney; Vice-President, E. B. Warren; Secretary, William G. Foulke; Treasurer, Charles P. Perkins, and Solicitor, William C. Hannis.

**Department of Public Instruction.** The act of June 3, 1911, creating the Bureau of Medical Education and Licensure requires the registration at Harrisburg of all physicians practicing in the State of Pennsylvania. If you have not already registered, and have not received registration card, send at once for same to the Department of Public Instruction, Harrisburg, who will forward you a card for this purpose, which please fill out without delay. If this is done promptly, it will save future annoyance both to the bureau and to the individual practitioner.

**The Homœopathic Medical Society of the County of Philadelphia,** held its regular monthly meeting at Hahnemann College, Thursday evening, May 9, 1912, at 9 o'clock. The scientific program of the evening consisted of the following: "Abdominal Conditions of Importance Frequently Unobserved," Dr. J. W. Hassler, New York; "The Homœopathic Remedy in Aural Diseases," Dr. G. J. Palen; "A Few Chest Indications," Dr. Malachi W. Sloan. Nomination of officers for the ensuing year took place. The meeting was a very interesting one and was well attended.

Wm. M. Sylvis, M. D., Secretary.

**The Germantown Homœopathic Medical Society,** held its regular monthly meeting at the Majestic, Broad and Girard avenue, on Monday, May 20, 1912, at 9 o'clock in the evening. Dr. Bradley told of "Cancer of the Stomach," which was very interesting, and was enjoyed by all present. The censors reported the following names: Dr. Hugh M. Shannon, Hahnemann, 1907, Dr. Deacon Steinmetz, Hahnemann, 1905.

Landreth W. Thompson, M. D., Secretary.

**The Clinico-Pathologic Society of Philadelphia**, held its regular monthly meeting at Hahnemann College, Saturday evening, May 18, 1912, at 8.30 o'clock. A paper on "The Necessity of the General Practitioner," was read by Dr. Joseph C. Guernsey, and one on "The Report of Results of Injection of Salvarsan in Fifty-two Cases," was read by Dr. J. M. Kenworthy. A number of interesting clinical cases were presented. The meeting was well attended and enjoyed by all present.

Benj. K. Fletcher, M. D., Secretary.

**The Philadelphia Society for Clinical Research**, held its regular monthly meeting at the office of the Secretary, Dr. Walter J. Snyder, 5300 Spruce street, on Wednesday evening, May 15, 1912, at 9 P. M. A paper was read by Prof. J. E. James on "The Need of a Special Study of Obstetrics." Dr. Mercer, of 1705 Arch street, added much interest to the meeting.

Walter J. Snyder, M. D., Secretary.

**The Homœopathic Medical Society of the Twenty-third Ward**, held its regular monthly meeting on Wednesday, May 15, 1912, at the Hotel Phoenix, Willow Grove. A paper was read by Dr. A. C. Heritage on "Locomotion" and was well presented. There was a full attendance of members and the meeting was a very interesting one.

J. D. Boileau, M. D., Secretary.

**The Delaware County Homœopathic Medical Society**, held its regular monthly meeting at the office of Dr. J. P. Van Keuren, 312 East Broad street, Chester Pa., on Thursday, May 16, 1912, at 3.30 P. M. Dr. J. W. Frank, Radiologist to the Hahnemann Hospital, Philadelphia, presented a paper on "The Use of High Frequency Current with Demonstration," which was enjoyed by all present. The election of officers for the ensuing year then took place, after which refreshments were served.

George C. Webster, M. D., Secretary.

**The Women's Homœopathic Medical Association of Pittsburgh, Pa.**, held its regular monthly meeting at the office of Dr. Clara H. Williams, 822 Wood street, Wilkinsburg, Pa., on Thursday, June 6, 1912, at 8 P. M. Reports were read of some very interesting cases, and plans for next year's work were arranged.

Mary E. Coffin, M. D., Secretary.

**The Carl V. Vischer Medical and Surgical Society of Philadelphia**, held its annual banquet at the Hotel Majestic, Broad street and Girard avenue, on Tuesday evening, June 4, 1912, at 9 o'clock. The banquet was well attended and a very enjoyable time was had by those present. Many noted guests attended same, Dr. G. J. Palen acting as toastmaster.

**The Homœopathic Medical Society of the County of Philadelphia**, held its regular monthly meeting at the Hahnemann College, Thursday evening, June 13th, at 9 o'clock. The following scientific papers were read: "Industrial Scalp Injuries," Dr. H. L. Northrop; "Treatment of Tonsilitis," Dr. W. J. Guernsey; "Apis in Nose and Throat Conditions,"

Dr. Isaac Shallcross; "Mezereum in Tic-douloureux," Dr. J. L. Van Tine. The following officers were elected for the ensuing year:

President—Dr. H. L. Northrop.

First Vice-President—Dr. Norman Betts.

Second Vice-President—Dr. Julia G. Waylan.

Secretary—Dr. William M. Sylvis.

Treasurer—Dr. I. B. Gilbert.

Necrologist—Dr. William F. Baker.

Trustees—Dr. H. S. Weaver, Dr. W. H. Keim, Dr. T. H. Carmichael, Dr. E. M. Gramm, Dr. H. P. Leopold.

Censors—Dr. J. J. McKenna, Dr. J. R. Mansfield, Dr. W. C. Cheesman.

**The Annual Meeting of the Medical Club of Harrisburg** was held during the early part of June and the following officers were elected for the ensuing year:

President—Dr. Samuel Z. Shope.

Secretary—Dr. J. Harvey Miller.

Treasurer—Dr. John A. Sherger.

During the summer months when intestinal trouble is so common in infants owing largely to the changed condition in cow's milk, it is a good idea to put all bottle fed babies on Lacto Preparata, an all-milk infant's food, which does not require the addition of milk to make it nutritious. Reed & Carnrick of Jersey City, N. J., who make Lacto Preparata, have a little book on the baby's care, which they will be pleased to send upon request.

**The Goodno Homœopathic Medical Society** held its regular June meeting at the York Medical Club, York, Pa., on Thursday, June 13th. The following papers were presented: "A Resume of Office Cases," Dr. J. Ross Swartz; "Procrastination," Dr. E. T. Prizer; "Medical Ethics," Dr. P. A. Noll; "A Consideration of the Feet," Dr. R. F. Strayer; "A Rectal Case," Dr. R. E. Perkins; "A Plea for Medical Gynecology," Dr. J. W. Reith; "The Other End," Dr. G. W. Hartman; "The Perils of Milady," Dr. J. E. Dehoff. The following members and guests were present: Drs. J. Ross Swartz, Harrisburg; J. H. Yeagley, York; J. W. Dehoff, York; J. A. Shower, York; G. W. Hartman, Harrisburg; E. T. Prizer, Lancaster; S. S. Mann, Columbia; J. L. Moyer, Columbia; W. E. J. Bomberger, Harrisburg; F. L. Richards, Mt. Joy; John Reith, Lancaster; C. H. Smith, York; G. B. Weaver, Lancaster; M. S. Bringman, York; R. L. Perkins, Harrisburg; P. A. Noll, Glen Rock; J. E. Dehoff, York; S. W. Brose, York; B. F. Parker, York; H. C. Brown, Lancaster; G. W. Ramsey, Harrisburg.

**Corner Stone of Hospital Laid.**—The corner stone of the new building of the West Jersey Homœopathic Dispensary and Hospital was laid Saturday, June 29th. The new building is located at Mt. Ephraim and Atlantic avenues, Camden, N. J. A number of appropriate addresses were made and great enthusiasm was shown in the growth of the institution.



# THE HAHNEMANNIAN MONTHLY NEWS AND ADVERTISER

A Medical Newspaper

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AUGUST, 1912

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**Surgical Clinics of John B. Murphy, M. D., Vol. I, No. 2.** The Surgical Clinics of John B. Murphy, M. D., at Mercy Hospital, Chicago. Vol. I, No. 2. Octavo of 291 pages, illustrated. Philadelphia and London: W. B. Saunders Company, 1912. Published Bi-Monthly. Price per year, paper, \$8.00; cloth, \$12.00

The first number of Murphy's clinics appeared in February, 1912, and immediately attracted considerable attention on the part of the members of the profession because of the interesting style and eminently practical nature of the material presented. The present volume deals with about twenty different surgical subjects, among the most interesting of which we note "Arthritis of the Knee Joint," "Salvarsan," "Gastric Ulcer" and "Anastomosis of the External Popliteal Nerve."

**Kidney Diseases.**—By W. P. Herringham, M. D., F. R. C. P., Physician to St. Bartholomew's Hospital, etc., etc., with chapters on Renal Diseases in Pregnancy, by Herbert Williamson, M. D., F. R. C. P., Assistant Physician Accoucheur to St. Bartholomew's Hospital, etc., etc. London, Henry Frowde, Oxford University Press, Warwick Square, E. C.

This book is the outcome of many years of work in hospital and private practice. It deals with the subject of kidney diseases from the standpoint of the clinician and while a few sections have been devoted to anatomy and physiology of the kidneys, almost the entire 365 pages are taken up with the practical diagnosis and management of kidney diseases. The author discusses the normal and abnormal constituents of the urine, the various forms of albuminuria, methods of examination of the renal functions, various forms of acute and chronic nephritis, functions of the pelvis, of the kidney, renal tumors, calculi, etc.

The work is a thoroughly commendable one in every respect and will prove of the utmost assistance to the medical practitioners who desire the latest information in this department of medical science.

**Tuberculin Treatment.**—By Clive Riviere, M. D., London, F. R. C. P., Physician East London Hospital for Children, etc., etc., and Egbert Morland, M. B., and B. Sc., London, M. D. Berne, of Arosa, Switzerland, Visiting Physician to the English Sanatorium. London, Henry Frowde, Oxford University Press, Warwick Square, E. C., 1912.

By a singular coincidence it happened that each of the writers of this book became aware that the other was about to publish a manual for tuberculin treatment. Fortunately for the profession they agreed to present the results of their experience with tuberculin in one volume, thus widening the scope of the work and increasing its value in many ways. The work covers the entire field of the clinical uses of tuberculin including its diagnostic and therapeutic applications. The immense value of tuberculin in the treatment of tuberculosis is being daily recognized by those who have had an opportunity to give it a fair trial and any physician who will carefully read this volume will be impressed with the importance of the subject.

A rather extensive acquaintance with the literature of tuberculin leads us to express the opinion that no more rational or practical work on tuberculin has yet been presented to the profession.

**Gonococcal Infections.**—By Major C. E. Pollock, Royal Army Medical Corps, and Major L. W. Harrison, Royal Army Medical Corps. London, Henry Frowde, Oxford University Press, Warwick Square, E. C., 1912.

During recent years emphasis has been placed upon the fact that gonococcal infection is not always a local disease but, on account of its tendency to produce permanent derangements of the genito-urinary organs and even to distant structures in the body it constitutes a condition which deserves the most serious consideration.

The authors of the volume now before us have approached this subject with its seriousness in mind and have reviewed the diagnosis and treatment of gonococcal infection in the most admirable manner. The uses of the new organic compound of silver and the scope and effects of

the vaccine treatment have been carefully described. The work is a very practical one and sets forth very clearly and comprehensively the modern management of this disease.

**Stomatology in General Practice.**—A Textbook of Diseases of the Teeth and Mouth for Students and Practitioners. By H. P. Pickerill, M. D., Ch. B., M. D. S., (Birm.), L. D. S., (Eng.), Hon. Stomatologist to the General Hospital, Dunedin, etc. London, Henry Frowde, Oxford University Press, Warwick Square, E. C., 1912.

The importance of the care of the mouth from the standpoint of general health has received permanent recognition during the past few years. It is, therefore, essential that practitioners of medicine should be familiar with the pathology and means of treatment of the more common diseases arising from the oral mucous membranes, teeth and jaws. In the present volume the author has endeavored to present the pathology, diagnosis and remedial treatment of these conditions.

Another important section of the book is that devoted to the effects of stomatic disease upon the teeth, and oral tissues.

It is a subject which has received but little attention from physicians in the past and the work will fill an important place in medical literature.

**Retinoscopy (or Shadow Test) in the Determination of Refraction at One Meter Distance, with the Plane Mirror.**—By James Thorington, A. M., M. D., author of "Refraction and How to Refract," etc., etc. Sixth edition, revised and enlarged with sixty-one illustrations, ten of which are colored. Philadelphia, P. Blakiston's Son & Co., 1012 Walnut street, 1911. Price, \$1.00 net.

This work is an abstract of the author's writings and lectures on retinoscopy, delivered at Philadelphia Polyclinic Hospital. In it the author has endeavored to present retinoscopy as a valuable objective method of estimating the refraction of the eye. It is a work which has met with considerable popularity on the part of the profession and is now in its sixth edition.

**A Text-Book of Gynecology.**—By William Sisson Gardner, M. D., Professor of Gynecology, College of Physicians and Surgeons, Baltimore, Md., with one hundred and thirty-eight illustrations in text. New York and London, D. Appleton & Co., 1912.

This book is a brief resumé of the field of gynecology and is designed particularly for medical students. The facts have been stated briefly and clearly. Most attention being given to common diseases, and rare diseases, and the strictly surgical phases of the subject have been largely omitted. The book is well illustrated and is well suited for the purposes for which it is designed.

**Practical Anatomy, An Exposition of the Facts of Gross Anatomy from the Topographical Standpoint and a Guide to the Dissection of the Human Body.** By John C. Heisler, M. D., Professor of Anatomy in the Medico-Chirurgical College of Philadelphia, with 366 illustrations of which 225 are in color by E. F. Faber. Philadelphia and London. J. B. Lippincott Company. Price, \$4.50.

This work is designed to serve as a guide to the student in the dissecting room. In recognition of this fact the details of each region of the body are presented in the order of dissection and the illustrations



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## Homœopathic Medical Society *of the* State of Pennsylvania

*Annual Meeting*

DELAWARE WATER  
GAP :: September  
17, 18 and 19, 1912

are arranged serially in order to show the structures to be encountered at successive stages of the work.

The book is bound with a flexible back and contains excellent illustrations. It can be recommended as a practical and a reliable guide to the student of practical anatomy.

**Collected Papers by the Staff of St. Mary's Hospital (Mayo Clinic) 1911.** Octavo of 603 pages, illustrated. Philadelphia and London. W. B. Saunders Company, 1912. Cloth, \$5.50 net.

The publication of the "Collected Papers by the Staff of the Mayo Clinic" has become an event that is looked forward to with considerable interest by a large proportion of the medical profession. The value of these papers lies in the fact that they contain an up-to-date summary of the diagnostic and surgical procedures that have proven valuable in practical experience in the management of a great variety of disease conditions.

The present volume deals with the "Alimentary Canal," "Hernia," "Genito-Urinary Surgery," "Ductless Glands," "Thorax and Extremities," "Surgical Technique" and a few additional papers on subjects of interest to physicians.

The papers dealing with the subject of "Gall Stones" are of great importance. Dr. William J. Mayo shows quite conclusively that the so-called innocent gall stones are a myth.

The modern methods of diagnosis in surgical diseases of the kidney and ureter are also dwelt upon quite fully, and a great deal of valuable original information is given. The volume is indispensable to the surgeon or medical internist who desires to avail himself of the most recent information along these lines.

**The Pituitary Body and Its Disorders; Clinical States Produced by Disorders of the Hypophysis Cerebri.** By Harvey Cushing, M. D., Associate Professor of Surgery the Johns Hopkins University, etc. An amplification of the Harvey Lecture for December, 1910. 319 illustrations. Philadelphia and London. J. B. Lippincott Company. Price, \$4.00.

This work is the result of original study made upon a series of forty patients affected with hypophyseal disease. It contains the most important contribution to the subject that exists in the English literature and contains a vast amount of original information that cannot be obtained from any other source. It is being more and more recognized by diagnosticians that disease of the pituitary gland is by no means uncommon and is frequently overlooked due to a lack of knowledge on the part of physicians in general, of the symptomatology of these conditions.

The present volume is divided into three sections: Section I deals with Anatomy, Physiology, Pathology and Chemistry of the Pituitary Body.

Section II deals with the Clinical Manifestations of Disordered Function of the Pituitary Body and Section III deals with the Symptomatology and Treatment.

The work is profusely illustrated by a large number of original photographs and drawings and the general typography of the work is most excellent. Dr. Cushing is to be congratulated upon his valuable contribution to American medical literature.

## PENNSYLVANIA STATE NOTES.

The Chester, Delaware and Montgomery Counties Homœopathic Medical Society, held its regular meeting at Three Tuns, Ambler, Pa., on Tuesday, June 11, 1912. A large number participated in the meeting. Dinner was served at 2 o'clock and a very delightful time was had by those who attended.

Isaac Crowther, M. D., Secretary.

The West Philadelphia Homœopathic Hospital, held its final festivities on the hospital lawn, on Tuesday evening, June 18, 1912. It being the last night of the fete, there was a large attendance present. The proceeds of the fete will be devoted towards improving the hospital.

**State Medical Society.**—Are you a member of your "State Medical Society?" If not, why not? Can you give anyone a good reason why you should not endorse your "State Medical Society" with your membership? Do you realize that you are not considered to be in good standing in your profession, unless you do endorse your State Medical Society? Perhaps you are not aware of the fact that on two occasions recently, two homœopathic physicians made application for state government positions, neither one of whom received the respective appointments which they desired, because of the fact that one was not considered to be in good standing in his profession, because he was not a member of his State Medical Society, and the other one, although a member of his State Society, had not paid his dues for several years back, and, therefore, was likewise considered "not in good standing."

Moral, join your State Medical Society, and "pay your dues." You may never want to seek a state government position, or a position in your municipality, but you must always know that you do not have the unqualified endorsement of your fellow practitioners, or government officials if you are not a member of your State Medical Society.

The younger men of the profession should see to it at once that they make application for membership, and become in good standing as early in their careers as is possible.

If you are already a member of your State Medical Society, then you have done the part of your duty at least. If you have seen to it that new members are joining the State Society through your own efforts, then you are doing your whole duty.

This year's meeting at the "Kittatinny" at the Delaware Water Gap, in September is to be a gala occasion. Dr. Gilbert J. Palen, our State Society President, is exerting every effort to make this year's meeting the best in the history of our "State Society."

On Tuesday evening there will be a smoker which will eclipse anything ever previously attempted. You should be on hand Tuesday evening for this occasion, because there will be special features, which you had better enjoy and participate in.

On Wednesday evening the State Society banquet is scheduled, a feature which was instituted last year at the successful Bedford Springs meeting.

You will find in this issue of this journal an application blank for membership, which you will kindly fill out and forward to the undersigned, together with your check for \$5.00, which includes everything for



the first year, reminding you of the "Hahnemannian Monthly," the official journal of the State Society, which comes to you each month.

Ralph Bernstein, Chairman,  
37 South Nineteenth Street,  
Philadelphia, Pa.

**The Germantown Homœopathic Medical Society** held its regular monthly meeting at The Majestic, Broad and Girard avenue, on Monday, June 17, 1912, at 9 o'clock in the evening. Dr. Clarence Bartlett entertained the meeting, his subject being "Odds and Ends—Diagnostic and Therapeutics." The meeting proved a very interesting one, and there was a full attendance of members.

Landreth W. Thompson, M. D., Secretary.

**The Homœopathic Medical Society of the 23rd Ward of Philadelphia.** held its regular monthly meeting on Wednesday, June 19, 1912, at the office of Dr. Wm. C. Powell, Bryn Mawr, Pa. A paper on "Arterio-Scleroses" was read and enjoyed by all present.

J. D. Boileau, M. D., Secretary.

**The West Philadelphia General Homœopathic Hospital and Dispensary Society** held its regular monthly meeting at 1234 North Fifty-fourth street, on Monday, July 1st, at 3.30 P. M. Many interesting topics were discussed, and the meeting was a very interesting one.

W. Hays Brown, M. D., Secretary.

**The West Philadelphia Homœopathic Hospital** held its annual meeting of the corporation, at 1234 North Fifty-fourth street, on Friday evening, June 14, 1912, at 8 o'clock. Many matters of importance were discussed, and there was a full attendance of members.

John S. Wilson, Secretary.

**Hospital Building Dedicated.**—The dedication of the new building of the Woman's Southern Homœopathic Hospital, at Broad and Fitzwater streets, took place on Friday afternoon, June 28th. Some two hundred friends of the hospital were present at the meeting, which was opened with prayer by the Rev. Edward Yates Hill, of the First Presbyterian Church.

The solo and chorus singing of a group of children from the Baptist Settlement House, as well as the addresses, were much enjoyed. Miss A. M. Miller, Secretary of the Board of Managers ever since the hospital was organized, told of the experiences and struggles of the early days; Dr. Theodore L. Chase spoke most highly of the character of work done in the old building; Miss E. S. Lowry, President of the New Century Club, made a few remarks in an encouraging vein; Mrs. E. S. Webster, the able treasurer for many years, gave a condensed financial statement and made a plea for help in bearing the heavy burden of debt; and the dedicatory prayer was offered by the Rev. Herman L. Dubring, a long-time friend of the hospital.

The visitors inspected the building, which is a splendid plain structure, an ornament to South Broad street, built of brick with a granite base and cream terra cotta trimmings. It has five stories and a tiled roof garden, four sun balconies, five adult wards and two children's wards and seventeen private rooms. The dispensary, dining rooms and kitchens

are in the basement; administration and family rooms on the main floor; maternity, medical and surgical floors are the first, second and third.

The building is vapor heated and electric lighted; has an electric elevator and vacuum cleaner; has a silent nurse signal system and is fitted for cooking by gas and electricity. It is of fireproof and sanitary construction throughout. The architect is Mr. E. Simpson Lemmon, whose devotion to the interests of the Board of Managers and careful attention to detail have made possible this admirably constructed building.

The lot is 120 by 130 feet in size and the plan is to erect a laundry and nurse's home in the near future. The Board will welcome contributions of any size.

**Notice.**—The Committee on Organization, Registration and Statistics of the Homœopathic Medical Society of the State of Pennsylvania desires to have a complete list of all the local Homœopathic Medical Societies in the State together with all hospitals, dispensaries and institutions which are under homœopathic control, or have homœopathic physicians in attendance. The committee urges all those receiving requests for information from the committee to respond promptly, and requests that any one having knowledge of any society, hospital, dispensary or institution other than those contained in the list published in the May "Hahnemannian" notify the committee so that information blanks may be sent them, and the annual report made more complete.

E. H. Pond, M. D., Chairman,  
902 Keenan Building,  
Pittsburgh, Pa.

**Personals.**—Rev. and Mrs. Charles C. Walker announce the marriage of their daughter, Imogene, to Dr. LeRoy I. Walker, on Wednesday, June 12, 1912, Philadelphia.

Dr. Joseph H. Fobes, No. 1 West 68th street, New York City, has returned to his office and will be in the city all summer. Office hours 11 to 1 daily except Sunday.

**Obituary.**—Dr. Thomas D. Clegg died in Philadelphia, on Wednesday, June 16, 1912. Funeral services were held on Saturday afternoon, at 2 o'clock.

**The New England Medical Gazette.**—We regret to observe that Dr. H. H. Watters, who for several years has so ably conducted the editorial management of this well known homœopathic medical journal, has resigned from the staff of the journal in order to devote more attention to his work in connection with the pathological laboratories of the Boston University School of Medicine.

The management of the journal has been fortunate in securing Drs. DeWitt, G. Wilcox and Arthur H. Ring, as the successors to Dr. Watters.

During the forty-six years of its publication, the New England Medical Gazette has stood for all that has been ethical and progressive in medicine. We congratulate it on its past record and extend to the new editors our cordial wishes for a useful and successful future.

**Hahnemann Medical College.**—At the last meeting of the Alumni Association of Hahnemann, of Philadelphia, Dr. D. P. Maddux, of '83, who is our representative of the new Bureau of Medical Education and

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expected from this faithfully-prepared and  
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Licensure, made some remarks that were received with unusual satisfaction by the "old grads."

Dr. Maddux stated that one of the highest, if not the very highest, authority upon pedagogy in this country had remarked to him that he considered Hahnemann of Philadelphia ahead of every other medical college in the State in its pedagogic methods; and when asked in what respect he considered Hahnemann ahead replied, "from top to bottom: it uses its material better, and its methods of instruction are more practical."

This encomium, coming entirely unsolicited, from one who had a special opportunity of making a critical comparison, is of highest value, and but confirms the facts that were known to those who realized the marvelous transformation of "Old Hahnemann" by the new Dean.

**Hahnemann Alumni Reunion.**—Hundreds of alumni of the Hahnemann Medical College arrived in this city from all sections of the country to attend the annual "Homecoming Week" of that institution, and the commencement exercises of the graduating class.

The reunion took place at the banquet of the Alumni Association at the Bellevue Stratford, Wednesday evening, June 5th. The graduation exercises were held at the Academy of Music, Thursday afternoon, at which the former students of the college were present. Clinton Rogers Woodruff delivered the commencement address.

In the afternoon a series of lectures, clinics in surgery, gynecology, the eye, ear and throat, and demonstrations were held at the college by some of the most prominent physicians in the country.

The alumni began the social part of their reunion Wednesday evening with a smoker in the Fountain Room of the Continental Hotel. Addresses were made by several of the physicians present. Thursday at noon the classes of 1882 and 1892 and 1902 held reunions at the Union League.

Fifteen members of the class of '82 were present, and Dr. William E. Boericke, of San Francisco, spoke. About a score of the graduates of the class of 1892 were present at the dinner. Dr. W. W. Van Baun, of this city, had charge of the class of 1882, while Dr. H. A. Weaver acted as toastmaster for the class of 1892.

Thirty members of the class of 1902 attended the reunion and were entertained at a luncheon and at clinics by the Philadelphia members of the class.

**International Hahnemannian Association.**—The thirty-third annual convention of the International Hahnemannian Association was held on June 24, 25, 26, 1912, at Swampscott, Mass. A most admirable spirit of enthusiasm and harmony prevailed at all of the numerous sessions of the three days' meeting. Nine full sessions were held without any falling off of interest or attendance. The Bureau of Homœopathic Philosophy had fifteen admirable papers under the chairmanship of Dr. M. W. Turner, of Brookline, Mass. Dr. Frank W. Patch, of Framingham, Mass., was chairman of the Bureau of Materia Medica and presented thirteen papers by as many eminent homœopathic physicians. One extremely interesting feature of this Bureau was the demonstration of the Margaret Tyler Perfected Card Repertory, a wonderfully ingenious device for the finding of the remedy needed. The Bureau of Clinical Medicine, however, was the star bureau of the meeting, the chairman,

Dr. Mary Florence Taft, had so skillfully managed her task that a magnificent list of forty papers were presented, some from England, Italy, Japan as well as the United States, fully justifying the word "International" in the title of the Association. The Bureaus of Obstetrics and Surgery were also filled with excellent papers. No time was lost in non-essentials, the scientific matter engaging the entire attention of the audience. The place selected for the next meeting is Chicago. The officers for the year 1912-13 are as follows: President, J. B. S. King, Chicago, Ill.; Vice-President, Julia M. Green, Washington, D. C.; Treasurer, Wm. R. Powell, Philadelphia, Pa.; Corresponding Secretary, Frank W. Patch, Framingham, Mass.; Corresponding Secretary, P. E. Krichbaum, Montclair, N. J.

Dr. Katherine L. Storm, who several years ago patented the Storm Binder, has recently obtained patents in England and Canada on this supporter, also another patent in the United States, for improvements that have been made to meet the extended requirements for a high belt for floating kidney, ptosis, etc., with a minimum of pressure, heat and weight across the back of the patient.

**After Scarlet Fever and Measles.**—After the acute diseases of childhood there is no remedy that will do more to hasten convalescence than Gray's Glycerine Tonic Comp. Children are particularly responsive to the tonic effects of "Gray's" and it is always gratifying to see the prompt improvement in the appetite, digestion and general nutrition that follows its administration. The palatability and clean bitter taste of "Gray's" make it exceptionally acceptable to children.

Boericke & Tafel report that the comparatively dry spring has been very favorable to the restocking of their fresh plant tinctures. *Lycopus Virginicus* seems to be in special demand, and a large new supply has been gathered. *Veratrum viride* is getting scarce, but a fine lot has been secured this spring, and a year's supply is assured.

**Report of the Treasurer of the American Institute of Homœopathy.**—Dr. Thomas Franklin Smith, Treasurer, shows that a balance of \$256.93 is to be carried forward to the coming year. The cost of maintaining the Field Secretary's work for the year was \$4,332.61. The journal cost \$4,116.69. It would seem from the Report of the Treasurer that the journal just about paid its own expenses.

**Report of the Field Secretary.**—Dr. Arndt, Field Secretary of the American Institute of Homœopathy, presented a very comprehensive and analytical report of the work done during the year and presented the following recommendations which are deserving of the serious consideration of every homeopathic physician:

I. Permanency of the work in the field is imperative if we are looking for permanent results. To accomplish this a plan must be devised which will relieve a small number of men of the necessity of paying the greater part of the unavoidable expenses. Such a plan must insure small but regular contributions from the rank and file. I believe a practical scheme can be devised by which there may be secured annual contributions for a period of years of, say, two dollars from every member of the profession. Such a moderate tax would be no hardship to anyone, and it would yield ample funds to conduct the work on a larger scale than you have been able to do in the past. If such a plan is

adopted and energetically carried out by a committee properly selected, thus becoming more than a resolution on paper, the work can be continued without fear of failure and without imposing upon anyone an unfair burden.

2. It is absolutely necessary to carry on a propaganda among the laity. Here co-operation between the Council of Education and the Field Secretary would be found most useful, and the special work of either would be much facilitated by occasional consultations between them.

3. There should be established at central points women's leagues to systematically co-operate with the profession in all work likely to advance local interests. We have been unwise in largely ignoring the special gifts of women which make them valuable aids, especially in getting at the people and in raising funds.

4. We must urge upon our people everywhere the need of greater zeal in securing qualified students for our colleges. The latter have shown a great deal of enterprise and a loyal determination to meet all requirements made upon them. Let the profession work equally hard to fill the lecture rooms and laboratories. The fact that we shall for years be unable to meet the demand for qualified homœopathic physicians is an assurance to graduates of homœopathic colleges that a good living is awaiting them, and that knowledge is a powerful consideration with prospective students of which we have not yet learned to make full use.

5. Assurance of permanency of the work in the field will immeasurably increase the interest of the profession in all that pertains to the Institute. Thus we may hope to have men become members of this body who have heretofore kept aloof. I feel safe in saying that the only consideration which will materially and continuously add to our numbers lies in the fact that the Institute is actually assuming responsibilities and trying to realize certain definite aims. If so, it is advisable not to waste our strength in encouraging the maintenance of sectional societies in parts of the country where we are not strong enough numerically and financially to support both State and sectional societies without lessening the possibility of securing from such territories active support and attendance upon the National organization. Common sense suggests the wisdom of a sensible economy of resources, and when sentiment chiefly is involved, it must yield to the stern logic of facts.

**Chairmen of Bureaus Appointed.**—Dr. Gilbert J. Palen, President of the Homœopathic Medical Society of the State of Pennsylvania, announces the appointment of the following Chairmen of Bureaus for the coming meeting of the State Society at Delaware Water Gap:

Gynaecology—Dr. Wm. A. Stewart, Pittsburgh, Pa.

Obstetrics—Dr. Aug. Korndoerfer, Jr., 1904 Spruce street, Philadelphia, Pa.

Ophthalmology and Otology—Dr. W. De Eaches, Phoenixville, Pa.

Paedology—Dr. J. M. Heinbach, Kane, Pa.

Materia Medica—Dr. William Seibert, Easton, Pa.

Sanitary Science—Dr. E. G. Whinna, Philadelphia, Pa.

Clinical Medicine Institute—Dr. O. H. Paxson, Philadelphia, Pa.

Pathology—Dr. J. Dean Elliott, 1420 Spruce street, Philadelphia, Pa.

Surgery—Dr. H. P. Leopold, 1825 Chestnut street, Philadelphia, Pa.

Members of the profession who desire to present papers under any of these bureaus are requested to communicate at an early date with the chairman of the particular bureau with which they wish to be associated.



# THE HAY FEVER PROBLEM

Preparations That Will Help You to Solve It.

## The Adrenalin Solutions

These are undoubtedly the most widely used products in the treatment of hay fever. They control the nasal discharge, allay congestion of the mucous membranes, and thus reduce the swelling of the turbinal tissues. They are prompt in action, reasonably certain, and have no deleterious constitutional or local effects.



## The Anesthone Group

Applied to the nasal mucous membrane these preparations afford prompt relief. They were used with marked success during the hay fever season of 1911. The fact that they afford relief which continues for several hours in many cases is worthy of consideration when one remembers the fleeting character of most local anesthetics.

### Solution Adrenalin Chloride

Adrenalin Chloride, 1 part; physiological salt solution (with 0.5% Chloretone), 1000 parts.

Dilute with four to five times its volume of physiological salt solution and spray into the nares and pharynx.

Ounce glass-stoppered bottles.

### Adrenalin Inhalant

Adrenalin Chloride, 1 part; an aromatized neutral oil base (with 3% Chloretone), 1000 parts.

Dilute with three to four times its volume of olive oil and administer in the manner described above.

Ounce glass-stoppered bottles.

### Anesthone Cream

Adrenalin Chloride, 1:20,000; Para-amido-ethyl-benzoate, 10%; a bland oleaginous base.

A small quantity (about the size of a pea) is applied three or four times a day, the patient snuffing it well into the nostrils.

Collapsible tubes with elongated nozzles.

### Anesthone Inhalant

Adrenalin Chloride, 1:10,000; Para-amido-ethyl-benzoate, 10%; an aromatized neutral oil base.

Apply with a nebulizer or by means of a pledget of cotton.

Ounce glass-stoppered bottles.

### Anesthone Tape

A selva-edge tape, one-half inch wide, impregnated with a 1:20,000 solution of Adrenalin Chloride and 5% soluble salt of Para-amido-ethyl-benzoate, agreeably perfumed.

A piece two or three inches long is cut off and inserted in each nostril.

Small vials.

**THE GLASEPTIC NEBULIZER.**—This is an ideal instrument for spraying the solutions above mentioned. It is at once aseptic, convenient and efficient. It is easily sterilized, the working parts being one piece of glass. It produces a fine spray and is suited to oils of all densities, as well as aqueous, spirituous and ethereal liquids. Competent authorities pronounce it the most practical atomizer ever offered to the medical profession. Price, complete (with throat-piece), \$1.25.

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*Annual Meeting*

DELAWARE WATER  
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## Acute Diarrhea of Infants

### MELLIN'S FOOD

4 level tablespoonfuls.

### WATER (boiled, then cooled)

16 fluidounces.

Give one to three ounces every hour or two, according to the age of the baby, continuing until stools lessen in number and improve in character. Milk, preferably skimmed, may then be substituted for water—one ounce each day—until regular proportions of milk and water, adapted to the age of the baby are reached.

This diet is especially serviceable for the feeding of infants with diarrhea for the following reasons:—

**Readily taken.**

**Completely utilized.**

**Protein-sparing**, thus preventing tissue waste.

**Furnishes sufficient body-heat** and energy and supplies enough nitrogenous food to maintain the baby's strength during the critical period.

**Maltose**, the predominating carbohydrate, has the highest point of assimilation and the lowest degree of fermentation of all sugars.

# THE HAHNEMANNIAN MONTHLY NEWS AND ADVERTISER

A Medical Newspaper

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SEPTEMBER, 1912

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**Digestion and Metabolism.**—The Physiological and Pathological Chemistry of Nutrition. For students and physicians. By Alonzo Englebert Taylor, M. D., Rush Professor of Physiological Chemistry, University of Pennsylvania, Philadelphia. Octavo, 560 pages. Cloth, \$3.75 net. Lea & Febiger, Philadelphia and New York, 1912.

The Physiological and Pathological Chemistry of bodily functions are generally considered among the most difficult of comprehension of all subjects in medicine, but if they can be viewed as actual processes, or seen as moving pictures, an understanding of them becomes comparatively easy. In this work Professor Taylor has discussed his subject in exactly this way, or from the standpoint of dynamics, rather than of statics. He has also presented it without the burden of technical detail. He first considers the composition of foodstuffs, and then follows them through digestion and absorption to their ultimate metabolic modifications. The



abnormal is considered along with the normal, a feature which makes for the easy understanding of the pathological variations of these processes, that produce gout, diabetes, nephritis, auto-intoxication, etc. In a word, the aim is to give the student and practitioner a working knowledge of just what is known to occur in the chemistry of the normal body and also of the morbid changes concerned in many common and important diseases.

**The Surgical Clinics of John B. Murphy, M. D., at Mercy Hospital, Chicago.**—Volume I. Number 3. Octavo of 174 pages, illustrated. Philadelphia and London. W. B. Saunders Company, 1912. Published bi-monthly. Price per year: Paper, \$8.00; Cloth, \$12.00.

In the June issue of "Murphy's Clinics" we find presented fourteen subjects of practical interest to the surgeon and the internist. Among these we note a discussion of "Colles's Fracture," "Cystic Goitre," "Gall Stones," "Typhoid Spine," "Potts' Fracture," etc. An important feature consists in the presentation of cases previously operated upon, with comments, figures and skiagrams showing the results of the operation treatment.

**A Text-Book of Pathology for Students of Medicine.**—By J. George Adami, M. A., M. D., F. R. S., Strathcona Professor of Pathology and John McCrae, M. D., M. R. C. P., (London) Lecturer in Pathology and Clinical Medicine. Illustrated with 304 engravings and 11 colored plates. Price, \$5.00 net. Lea & Febiger, Philadelphia and New York, 1912.

Any work on pathology emanating from the pens of such writers as Professors Adami and McCrae, is sure to receive the thoughtful consideration of every scientific medical practitioner. A review of the volume now before us shows that the writers have produced a work worthy of the highest commendation, and one that places before the student and practitioner of medicine in a comparatively condensed form, all of the important facts and principles of modern pathology.

The work is divided into two parts. Part I is devoted to General Pathology, dealing principally with the various principles involved in Inflammation, Infectious Diseases, Immunity, Degenerations, Tumors, etc. Part II is devoted to Special and Systemic Pathology. In this section of the work, the pathological considerations involving the various tissues and organs of the body are taken up and considered in detail. The portions of the work dealing with the modern views of infection and immunity are of the greatest importance and contain a complete and up-to-date summary of our knowledge in this important branch of medicine.

The work is well illustrated, the text is arranged in such a form that the important facts are readily obtainable, and the entire work is of such character as would commend it most highly to the medical practitioner and student desiring the latest and most authoritative information on medical pathology.

**The Care of the Skin and Hair.**—By William Allen Pusey, A. M., M. D., Professor of Dermatology in the University of Illinois. New York and London, D. Appleton & Co., 1912.

This little volume has been designed to furnish laymen with such information as will be of practical help to them in caring for the skin and hair. It deals with the hygienic care of these structures and not with the medical treatment.

There is, no doubt, a demand for a work of this character written

by a reputable authority and Dr. Pusey's work will, no doubt, meet with a favorable reception.

**The West Branch Homœopathic Medical Society** held its regular monthly meeting on Thursday, August 8th, at Nippono Park, Williamsport. A paper was read by Dr. Bierman, of Bloomsburg, subject, "Lessons to be Learned from Cases of One Day's Practice," also a paper on *Materia Medica*, by Dr. E. C. Blackburn. The doctors were accompanied by their wives and Mrs. Anna Cheyney, of this city, and Dr. Bierman and family, of Bloomsburg, were guests of the society.

**The Ice Bag in Appendicitis.**—In a most interesting article by A. M. Fauntleroy, Surgeon of the United States Navy, *Medical Record*, August 3, 1912, the fact is brought out, basing the same upon a large number of cases of appendicitis operated, that the ice bag is positively harmful in this condition. In 50 per cent. of the cases operated, where the ice bag was used, the condition seemed to indicate that there was a noticeable lack of effort on the part of nature to wall off, from the rest of the abdominal cavity, the appendix, which was frequently very much congested, gangrenous or perforated. He also observed that in the ice bag cases there was a surprisingly low white cell count when one took into consideration the condition found in the abdomen at the time of the operation. From 8,000 to 11,000 white cells was the rule in these ice bag cases when one would be justified in saying that the pathological condition warranted a constitutional reaction of from 20,000 to 30,000 leucocytes, or even higher.

On the other hand, in those cases in which the hot water bag or morphine had been used prior to operation (the ice bag not being used at all), the white count corresponded to what one would expect. Dr. Fauntleroy advances from his findings the logic that while the ice bag causes numbness practically the same as in the condition of frost-bitten ear or toe, it also decreases hyperemia, leucocytosis and stasis in the part to which it is applied. That heat is the direct antithesis of cold in encouraging favorable physiological action in inflammatory processes, whether superficial or peritoneal, seems to be from his report most logically and conclusively proven.

In applying heat, whether it be for peritoneal or inflammatory conditions of a more superficial character, the most rational method is to use that which is not only sanitary, but, for the comfort of the patient does not require frequent changes. In this respect, antiphlogistine, on account of its heat retentive properties, its cleanliness, and its ease of application, should appeal to the professional mind. That antiphlogistine has proven of great therapeutic value as a thermic agent is best indicated by its extensive professional employment and its many advantages over the hot water bottle and other methods of application of heat is readily discernible.

**Southern Homœopathic Medical Association.**—The 29th session of the Southern Homœopathic Medical Association will be held October 15, 16, 17, 1912, in the auditorium of the Hotel Jefferson, Richmond, Va. The officers and bureau chairmen are making an earnest and determined effort to make this the most profitable meeting ever held. Come to Richmond. Bring a paper with you, or report some interesting cases. Dr. Wellford B. Lorraine, chairman of the local arrangements, writes, "We are busy now, but will be ready when you come."

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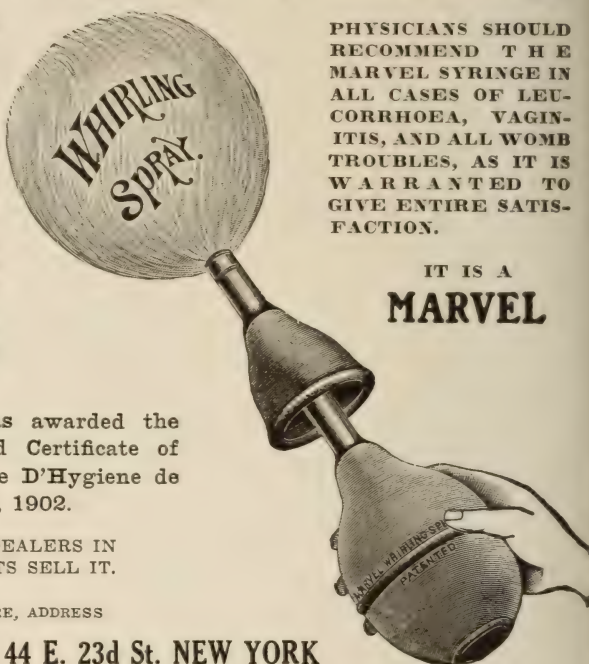
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## American Institute of Homoeopathy

DENVER, 1913

**A**FTER eighteen years the Institute returns to Denver. Let members determine that history shall repeat itself. Make the coming meeting meet the success of 1894. Write to the Secretary for particulars.

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**American Association of Clinical Research.**—The fourth annual meeting of the American Association of Clinical Research will be held in New York City, at the Academy of Medicine, on November 9, 1912. The sessions will be held from 9 A. M. to 1 P. M., from 3 P. M. to 6 P. M., and from 8 P. M. to 10 P. M. The evening session will be open to the public. Notable contributions on the Negri Bodies, on certain Fluids for Tubercle Bacilli in the Urine, on Adjustment and Function, on Psychoanalysis and Traumbedeutung, on a Pandemic of Malignant Encapsulated Throat Coccus, on The Single Remedy, on Indicanuria and Glycosuria, on Disease Conditions Expressive of Correct Diagnosis, on Biochemic Problems, on The Two Most Far-Reaching Discoveries in Medicine, and others are to be given. Every member of the Association is cordially invited to contribute a paper. The title should be sent at once to the permanent secretary, so that the program may be completed.

James Krauss, Secy.

As it is generally accepted that milk should not be given during the acute stages of diarrhea, it is necessary to select some diet other than milk that will furnish enough easily-assimilated nourishment to carry the baby through the critical period. The form of this nutrition should also be such as to prevent the destruction of the body proteins; otherwise, the baby patient is likely to undergo starvation to such an extent that the chances of recovery are much lessened. A diet of Mellin's Food and water meets these requirements in an effective and satisfactory manner.

Maltose, the predominating carbohydrate in Mellin's Food, is a pro-tein-sparer, and this, together with the amount of soluble proteins and the total food value in the mixture of Mellin's Food and water, is a safeguard against prostration—so much feared in cases of infantile diarrhea.

Mellin's Food is much to be preferred to barley or other cereal gruels, as it is not only free from starch, but contains ample nourishment and of the right kind, available for immediate assimilation.

**High-Potency Antitoxin.**—A noticeable preference for concentrated anti-diphtheric serum (globulin), as compared with the older or "regular" form of diphtheria antitoxin, has manifested itself among the medical fraternity. "High potency, small bulk," appears to be the order of the day. A good index to the tendency in this direction may be found in the offerings of the manufacturers, who, as a matter of course, are promptly responsive to each new demand of the profession. For confirmation of the belief that the concentrated product is now in the ascendancy, one has but to turn to the announcement of Parke, Davis & Co., in the current number of this journal, "Antitoxin that Justifies Your Confidence." Here one finds prominently featured the concentrated anti-diphtheric serum (or globulin). It is interesting to note in this connection that a wider range of dosage than formerly is now offered—from 500 to 10,000 antitoxic units—the larger doses, of course, being provided for severe, late or other exceptional cases. And herein, at least, is one undisputed point in favor of the concentrated antitoxin: when a large dose is needed, it can be administered in this form without difficulty and with little danger of disturbance, owing to the comparative smallness of its bulk.

Some physicians, it may be noted, are under a misapprehension as to the nature of the concentrated antidiphtheric serum (globulin), assum-

ing that it is widely different from the product which they have known for years as antidiphtheric serum. The idea is wholly erroneous. Concentrated antidiphtheric serum (globulin) is the regular product, precipitated and purified, from which most of the serum constituents have been eliminated except those bearing the antitoxin. It is in no sense inferior to the original serum—on the contrary, as previously noted, it possesses the advantage of lesser bulk.

**New York State Homœopathic Medical Society.**—The continued activity of the officers of this organization ensures the character of the event scheduled for Tuesday and Wednesday, October 8th and 9th, in Buffalo. The various chairmen and especially the local arrangements committee, are cordially supporting the work of the president. Every homœopath in the State should bear in mind the above dates and make plans to be present; for after the calm of the summer, one needs a fresh stimulus for the winter's study and work. The programme will be broad and practical, designed to put the practitioner in touch with the most recent developments and methods, but especially planned to cover the needs of the followers of the law of similars. The local committee, under the guidance of Dr. Wm. H. Marcy, desires a large attendance of both physicians and their wives and families.

Ample entertainment will be given the ladies by a group of Buffalo women, under the direction of Mrs. Joseph T. Cook, with the aid of physicians' wives and members of the Women's Board of the Buffalo Homœopathic Hospital. The social event of Tuesday will be an informal dinner at the Lafayette Hotel, in the evening. This will be a distinct and unique affair in several ways, and will include happy surprises at unexpected times and in unusual directions. There will positively be no toasts or after-dinner speeches. The women are especially invited to this function and will enjoy every moment of it, for there will be something doing most of the time.

On that day also the ladies will be shown about the city in motor cars, visiting Buffalo's charming parks and residential districts and its famous Albright Art Gallery.

On Wednesday noon, after the morning scientific session, the physicians and their ladies will be escorted from the Lafayette Hotel in "sight seeing" cars, to the new Buffalo Homœopathic Hospital, where they will be entertained by the local profession at an informal standing luncheon, being assisted by the local women's committee and the president of the women's board of the hospital.

Following the luncheon, the guests will be shown over this, the newest and most up-to-date hospital in the country—one that any city and all homœopaths may justly be proud of. This opportunity for a close inspection of the hospital will, no doubt, attract many to the meeting.

The fact that Buffalo is only forty minutes distant from Niagara Falls, should not be overlooked. October is an ideal month to visit Niagara. The transportation committee has arranged for a rate of a fare and two-fifths on the certificate plan, if one hundred or over attend, of which further details will be given in the official programme.

A very interesting exhibit of medical and surgical specialties will be arranged in a parlor of ample size at the headquarters hotel. All sessions will be held at the Lafayette Hotel. The hotel management is making unusual plans for the comfort of the members at very moderate rates.

The entertainment committee is composed of Dr. George R. Critch-

low, as chairman, with the aid of Drs. Maycock, Mosley, Pinkerton and Case. These names are a guarantee that those who attend will be thrice glad.

Willis B. Gifford, President.

In order further to popularize the demand for Bacterins—(Bacterial Vaccines)—and enable physicians to make more general use of these products, we call attention to the downward revision of prices on Mulford's Bacterins, effective August 5th.

The Mulford Bacterins are in every case "polyvalent," which means that the bacteria contained in a Bacterin, although of the same species, are obtained from many different sources. For instance, Strepto-Bacterin is polyvalent, the bacteria used for its preparation are all streptococci and are isolated from different patients suffering with streptococcic infections among which may be mentioned puerperal sepsis, general septicemia, erysipelas, tonsillitis, empyema, cellulitis, etc.

A number of the Mulford Bacterins are "mixed" by which is meant that they contain the various bacterial species generally present in a mixed infection. For instance, the mixed vaccine of chronic gonorrheal infections, besides the gonococcus contains various staphylococci, colon bacilli, streptococci, and other organisms isolated from cases of chronic urethritis and prostatitis.

In some cases, diseases from their inception are due to mixed infections, while in many others the infection becomes a mixed one as the disease develops. Past experience and results have fully established the advantages claimed for these "polyvalent" and "mixed Bacterins."

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#### PENNSYLVANIA STATE NOTES.

**State Medical Society.**—But a few days remain for the meeting of the State Medical Society, and all is in readiness for the occasion. An unusually good scientific program has been arranged which, no doubt, will more than appeal to you.

The entertainment program has not been neglected. On Tuesday evening there will be a smoker which will surpass any smoker ever previously held. There will be a special feature on this occasion to give you something long to remember, and there is a banquet scheduled for Wednesday evening, which in itself is to be a gala occasion. An automobile sociability run has as well been arranged for those who care to make the run from Philadelphia to the Water Gap, stopping at various points on the way, taking up the doctors who have entered for this occasion.

Entertainment for the ladies has as well been considered. An automobile run through the Water Gap, and everything else that will assist in their stay pleasant is in charge of Mrs. W. A. Stewart of Pittsburgh.

The membership committee has been hard at work, and it is almost ready to present its report. If you have not already become a member of the State Society, you will have an opportunity to do so. If you are a member, and have not already sent in the names of your neighboring physicians there is still time for that.

Remember, Doctor, that the time has come when physicians are no longer considered to be in good standing unless they endorse their State Medical Society with their membership, not only among the members of



the fraternity at large, but as well by government officials. Therefore, if you are not already considered in good standing it is your paramount duty to become so at once. This can be readily accomplished by filling out the application blank which you will find attached to this issue of the Hahnemannian Monthly. Send same with check for \$5.00 to the undersigned at 37 South Nineteenth Street, Philadelphia, remembering that this includes everything for the first year, your initiation, your dues and the Hahnemannian Monthly, which comes to you monthly.

Ralph Bernstein, Chairman.

**Personals.**—Dr. Edward Muhly announces the removal of his offices to 1508 South Broad street, Philadelphia.

Dr. Charles T. Haines, Hahnemann '98, desires to announce that he is open for engagements to act as substitute for physicians who are away on vacations.

Dr. J. H. McClelland, of Pittsburgh, spent part of the summer traveling in Switzerland.

Dr. Louis Rene Kaufman announces his removal to "The Paulette," 150-156 West 80th street, New York. Office hours, daily, 11.30 A. M. to 1 P. M. and by appointment. Sundays and holidays 9 to 10 A. M.

Mr. and Mrs. Arthur Crawley announce the marriage of their daughter, Luetta Marie, to Walter H. Hatfield, M. D., on Tuesday, July 2, 1912, 2112 Auburn avenue, Mt. Auburn.

Mr. and Mrs. John Fallonsbee announce the marriage of their sister, Euphemia Gifford Kerr, to Dr. Charles Sigmund Raue, on Saturday, July 20, 1912, Pittsburgh, Pa. At home after October 15th, 264 South Sixteenth street, Philadelphia, Pa.

**Obituary.**—Dr. John B. McClelland, of Pittsburgh, died on August 4, 1912. Dr. McClelland was an active member of the American Institute of Homœopathy and of the Homœopathic Medical Society of the State of Pennsylvania for many years. He was a brother of Dr. J. H. McClelland and Dr. Robert W. McClelland, with whom he was associated in practice.

Dr. C. P. Seip, of Pittsburgh, died from an attack of angina pectoris at Atlantic City on August 6, 1912. Dr. Seip has been an active member in the various homœopathic medical societies, both local and national since 1869. He was recently appointed a member of the new State Board of Medical Education and Licensure.

**For Sale.**—The West Philadelphia Homœopathic Hospital has just installed a 4 K. W. Wappler X-Ray machine, and is prepared to do all kinds of X-Ray work. There is an opportunity for some one to buy cheap their small Victor X-Ray and high-frequency coil. Address the hospital for further information.

**Office to Let.**—A first-class homœopathic physician needed immediately in North Philadelphia. Furnished office, good location, fine outlook. Heat, light and attendance free. Address all communications to "J. T.," care of Hahnemannian Monthly, 1631 Arch street, Philadelphia.

The State Homœopathic Insane Asylum, at Rittersville held a reunion on Thursday, July 25th, and was attended by more than 200 physi-

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cians of the homœopathic school of medicine. While they came from all parts of Pennsylvania, it was Schuylkill, Luzerne, Berks, Carbon, Northampton, Bucks, Montgomery and Philadelphia Counties that were most largely represented.

The visitors, mostly members of the Eastern Homœopathic Association, were guests of the Lehigh Valley Society. They were greeted by Dr. Henry L. Klopp, superintendent of the asylum, and Dr. Frank J. Slough, of Allentown, one of the members of the Board of Trustees.

From 9 to 11 o'clock an army of guides conducted the visitors through the institution. After a luncheon, at which the local physicians were the hosts, the assemblage was called to order in the auditorium of the asylum by Dr. John J. Tuller, of Philadelphia, one of the trustees. Dr. E. C. Kinney, of Easton, read a paper on "Some Medical Problems and How We Shall Meet Them."

Dr. Howell, of Reading, spoke on "Colds and Their Treatment." Dr. Bullard, of Wilkes-Barre, delivered an address congratulating the homœopaths on securing an asylum in which their ideas of curing mental diseases will prevail.

Dr. Francis Boyer, of Pottsville, spoke on "Yellow Journalism in Medicine and Surgery," and Dr. Haman, of Reading, on "Inflammatory Complication Following Injuries of the Skull."

**The Homœopathic Medical Society of the 23rd Ward**, held its regular monthly meeting on Wednesday, July 17, 1912, at the office of Dr. D. B. Umstead. Some very interesting topics were discussed, and the meeting was thoroughly enjoyed by all present.

J. D. Boileau, M. D., Secy.

**The Philadelphia Society for Clinical Research**, held its regular monthly meeting on Thursday, June 27th, at 3 P. M., at the office of Dr. Walter J. Snyder, 5300 Spruce street. The members then attended a ball game at the links of the Athletic Club of Philadelphia, at Manoa, on the West Chester Pike. Dinner was then served to all members of the society, and proved to be a very pleasing feature of the day.

Walter J. Snyder, M. D., Secy.

**Extracts from the Report of the Field Secretary of the American Institute of Homœopathy**,—During the year which closes with the present session of the Institute, the Field Secretary has spoken to State and local societies in at least twenty-five States; of these, seventeen had not been previously visited. In the two years of his labors for this organization he has addressed the profession, in State or district meetings, in all the States of the Union save Arizona, Arkansas, Idaho, Montana, Nevada, New Mexico, South Carolina, West Virginia and Wyoming. The meetings, with almost no exception, were well attended, a fair, and often large proportion of our membership in the territories visited being present in nearly every instance.

All the colleges but one were visited during the last year. Through the kindly co-operation of their Deans these gatherings were well attended by the student bodies; they received me generously and listened to my addresses with evident interest.

I now feel competent to express a fairly reliable opinion concerning the status of the homœopathic profession in this country, and think it



quite safe to affirm that in everything but numbers we have during the last two years made material gain. We are now surrounded by an atmosphere of confidence in ourselves and in the future of our organization which stands in decided contrast with the despondency and diffidence of a few years ago; and this change for the better is sufficiently obvious to have constituted a very common topic for favorable comment and congratulation at the society meetings held in different parts of the country. . . . We took a big step in advance when we admitted to ourselves the need of doing many things we had ignored or considered of "no account." In two years we have changed from a body of men content to take it for granted that—*nolens, volens*—homœopathy was melting into nothingness under the fierce light of modern science; to-day we realize that modern science is not destined to destroy homœopathy, but is bound to strengthen it as it has never before been strengthened. This conception gaining ground, we took a renewed interest in the body which represents organized homœopathy, and the outcome is that instead of talking of a "ship that is sinking," and about the most dignified way of meeting the hour of rapidly approaching dissolution, we are making the ship stauncher than ever before and are taking note of the fact that the old vessel is fit for any cruise. It is far easier to-day, as a colleague stated not long ago in Ohio, to insure a good meeting or to get "something done," to have our people give of their time and substance for the common good, than it was in the recent past. Our gatherings have materially increased in interest and practical value, and our people are actually coming to the conclusion that it is worth while attending a medical society meeting even if it involves a sacrifice.

Again, it is absolutely useless to ignore the fact that there is much more homœopathy to-day in the homœopathic profession than there was a few years ago. We are no less willing to see the good in certain therapeutic measures outside of the homœopathic law than we were in the immediate past; but more homœopaths prescribe homœopathically to-day than they did a few years ago; and they do it with confidence and with satisfaction to themselves. Homœopathic materia medica, homœopathic therapeutics, and homœopathic doctrines hold a far more important place on our program than they did, and—strange to say—there have been society meetings during the last year where the chief interest centered in the discussion of the best and most practical way of selecting the homœopathic remedy in a given case. Although I have never been classed with the high potency men, I deem it a good sign to have the representative of one of our most distinguished pharmacies state that the sale of high potencies by his firm has, during the last year, shown a very decided increase. . . .

To sum up: (a) I believe we are making a reasonable growth, considering all the circumstances; (b) I believe a special committee on new members is still the best way of doing the work; (c) I believe the best time and place to perfect this organization is the time and place of the annual meeting, and there should be a call made for volunteers to undertake the work under the direction of a general chairman appointed by the president; (d) I believe we cannot afford to put a large expense into this work, and I am not sure that it is necessary to do so. Save in exceptional cases circularizing a certain territory is not profitable. The Institute should continue to furnish needed stationery, but aside from this it must remain a labor of love, and we must simply exert ourselves to the utmost, individually and collectively, to gather into the fold, and to hold

in the fold, every man and woman to whom homœopathy is something more than a trade-mark.

#### Recommendations.

After a thorough study of the field I beg to make the following recommendations:

I. Permanency of the work in the field is imperative if we are looking for permanent results. To accomplish this a plan must be devised which will relieve a small number of men of the necessity of paying by far the greater part of the unavoidable expenses. Such a plan must insure small but regular contributions from the "rank and file." I believe a practical scheme can be devised by which there may be secured annual contributions for a period of years, of, say, two dollars for every member of the profession. Such a moderate tax would be no hardship to anyone, and it would yield ample funds to conduct the work on a larger scale than you have been able to do in the past.

If such a plan is adopted and energetically carried out by a committee properly selected, thus becoming more than a resolution on paper, the work can be continued without fear of failure and without imposing upon anyone an unfair burden.

II. It is absolutely necessary to carry on a propaganda among the laity. Here co-operation between the Council of Education and the Field Secretary would be found most useful, and the special work of either would be much facilitated by occasional consultations between them.

III. There should be established at central points "women's leagues" to systematically co-operate with the profession in all work needful to the advancement of local interests. We have been unwise in largely ignoring the special gifts of women which make them valuable aids, especially in getting at the people in popularizing homœopathy and in raising funds.

IV. We must urge upon our people everywhere the necessity of greater zeal in securing qualified students for our colleges. The latter have shown a great deal of enterprise and a loyal determination to meet all requirements made upon them. Let the profession work equally hard to fill their lecture rooms and laboratories. The fact that we shall for years be unable to meet the demand for qualified homœopathic physicians is an assurance to graduates of our colleges that a good living is awaiting them; and the demand for homœopathic practitioners can be made a powerful consideration with prospective students of which we have not yet learned to make use.

V. Assurance of permanency of the work in the field immeasurably increases the interest of the profession in all that pertains to the Institute. Thus we may hope to have men become members of this body who have heretofore kept aloof, and I feel safe in saying that the only consideration which will add materially and continuously to our membership lies in the fact that the Institute is actually assuming responsibilities and is trying to accomplish certain definite aims. If so, it is advisable not to waste our strength in encouraging the maintenance of sectional societies in parts of the country where we are not strong enough, numerically and financially, to maintain both State and sectional societies without lessening the possibility of securing from such territories active support of and attendance upon the national organization. Common sense suggests the wisdom of a sensible economy of resources, and when sentiment chiefly is involved, it should yield to the stern logic of facts.

H. R. Arndt, M. D.

# THE HAHNEMANNIAN MONTHLY NEWS AND ADVERTISER

A Medical Newspaper

OCTOBER, 1912

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**Elementary Bacteriology and Protozoology: the Microbiological Causes of the Infectious Diseases.**—By Herbert Fox, M. D., Director of the William Pepper Laboratory of Clinical Medicine in the University of Pennsylvania. 12mo., 237 pages, with 67 engravings and 5 colored plates. Cloth, \$1.75 net. Lea & Febiger, Philadelphia and New York, 1912.

This work is designed as an elementary text-book of Bacteriology and Protozoology for nurses and for beginners. Without being technical, it gives a good idea of the nature of micro-organisms, and then discusses with more emphasis the ways in which bacteria pass from one individual to another, how they enter the body and act when once within, and their manner of exit. Such general information concerning the character of the disease process has been included as seemed necessary to clarify the nature of microbe action. Indeed, the subject-matter in many places is but elementary bacteriological pathology. In other words, the author has endeavored to show in the simplest manner how bacteria produce disease.



**A Treatise on Diseases of the Hair.**—By George Thomas Jackson, M. D., Professor of Dermatology in the College of Physicians and Surgeons, Medical Department of Columbia University, and Charles Wood McMurtry, M. D., Instructor in Dermatology in the College of Physicians and Surgeons, Medical Department of Columbia University, New York. Octavo, 366 pages, with 109 engravings and 10 colored plates. Cloth, \$3.75 net. Lea & Febiger, Philadelphia and New York, 1912.

Nearly every human being has some defect or slightly abnormal condition of the hair or scalp which, if it had received proper attention at the right time, might have been either cured or prevented. In spite of the great discomfort and the even greater disfigurement which many of these irregularities produce, and the intense suffering which nearly always results from the more severe diseases of the hair or scalp, they have not received, until recently, the study and investigation which their importance merits. For this reason there has grown up about them a tangle of erroneous ideas which has obscured the truth. The result is that the average physician feels himself helpless and hopeless when confronted with a case of this type. In recognition of the need for an adequate presentation of this important subject, Drs. Jackson and McMurtry have created the first work in this field which may justly claim to be authoritative, scientific and thoroughly practical. The sections on diagnosis and treatment have been made full and precise, and have been prefaced with a discussion of the pathology of the disease under consideration. The latest researches are included. An especially attractive feature has been made of the illustrations and colored plates.

**A Manual of Chemistry.**—A Guide to lectures and Laboratory Work for Beginners in Chemistry. A text-book specially adapted for Students of Medicine, Pharmacy and Dentistry. By W. Simon, Ph. D., M. D., Professor of Chemistry in the College of Physicians and Surgeons, Baltimore, and in the Baltimore College of Dental Surgery; Emeritus Professor in the Maryland College of Pharmacy; and Daniel Base, Ph. D., Professor of Chemistry in the University of Maryland. New (10th) edition, enlarged and thoroughly revised. Octavo, 774 pages, with 82 engravings and 9 colored plates, illustrating 64 of the most important chemical tests. Cloth, \$3.00 net. Lea & Febiger, Philadelphia and New York, 1912.

The degree of approbation accorded this work by the Medical, Dental and Pharmaceutical professions is shown by the demand which has exhausted nine previous editions, each in several large printings. This new revision makes its appearance at a most opportune season—namely when students are about to begin the academic year and when physicians, dentists, pharmacists and chemists are preparing for their winter's work. The manual still preserves the plan and characteristics which have won for it its greatest popularity. Numerous additions have been made, most of which are of fundamental importance and again bring it abreast of modern thought in chemistry. Ionic relations are discussed in practically every chapter on acids and the metals, and a number of compounds have been added to the sections on inorganic and organic chemistry. The section on physiological chemistry has been rewritten and brought in line with present-day knowledge and theories. Special care has been taken

to introduce here the most modern methods for chemical examination in clinical diagnosis. The facts and data which are of direct interest to the physician, pharmacist and dentist have been placed in the foreground.

**Sexual Impotence.**—New (4th) edition enlarged. By Victor G. Vecki, M. D., Consulting Genito-Urinary Surgeon to the Mount Zion Hospital, San Francisco. Fourth edition, enlarged. 12mo. of 394 pages. Philadelphia and London. W. B. Saunders Company, 1912. Cloth, \$2.25 net.

This work, now in its fourth edition, has received very favorable commendation from the members of the medical profession, both in America and Germany. The author has approached the subject in a very frank and logical manner and, after a thorough review of the physiology and anatomy of the subject, has given a rational and thorough review of the treatment of this condition.

**Surgical After-Treatment.**—By L. R. G. Crandon, M. D., Assistant in Surgery at Harvard Medical School, and Albert Ehrenfried, M. D., Assistant in Anatomy at Harvard Medical School. Second edition, practically rewritten. Octavo of 831 pages, with 264 original illustrations. Philadelphia and London. W. B. Saunders Company, 1912. Cloth, \$6.00 net; half morocco, \$7.50 net.

It is not surprising that a second edition of this excellent work has been called for within a very short time. Both in hospital work and in private practice the after-care of surgical cases is largely in the hands of either the house surgeon or the family practitioner and the successful outcome of the case is dependent quite as much upon the after-care the patient receives as upon the actual operation itself.

The volume now before us covers this subject most thoroughly. Every symptom and complication that is at all likely to occur after an operation is taken up and its significance and treatment carefully discussed.

In addition to the general consideration of these symptoms, the particular conditions to which attention must be given after operations on various special structures of the body, are considered in detail.

The work is invaluable to surgeons or medical men who come in contact with surgical cases.

**A Text-Book of Human Physiology**, including a section on Physiologic Apparatus, by Albert P. Brubaker, A. M., M. D., Professor of Physiology and Medical Jurisprudence in the Jefferson Medical College, Philadelphia, Pa. Fourth edition revised and enlarged with one colored plate, and 377 illustrations. Philadelphia, P. Blakiston's Son & Co., 1012 Walnut street, 1912. Price, \$3.00.

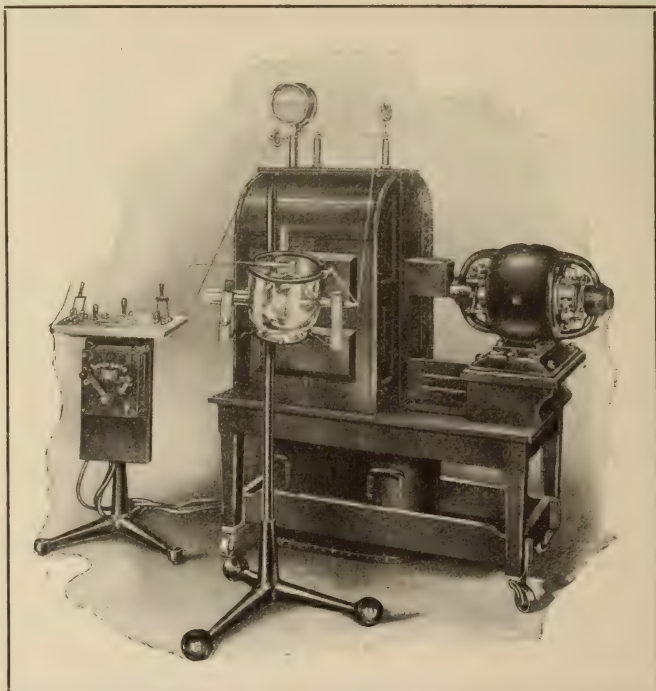
The publication of the fourth edition of this standard text-book on physiology has furnished an opportunity for revision and for the incorporation of considerable new matter.

In the present edition the author has adhered to his original plan of presenting the subject in such a manner as would not only elucidate the normal functions and the tissues and organs of the body but also be of assistance in understanding the abnormal manifestations as they present themselves in medical practice.

In the present edition we note considerable alterations and additions have been made in the chapters referring to the "Mechanical Movements

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of the Stomach and Intestines," "The Digestion and Absorption of Proteins," "The Physiology of the Heart Muscle," and the "Action of the Glands of Internal Secretion." It is a work that is well adapted to the needs of students or of medical practitioners.

**Oxford Medical Publications.**—**Manual of Surgery.**—By Alexis Thompson, F. R. C. S. Ed., Professor of Surgery, University of Edinburgh, and Alexander Miles, F. R. C. S. Ed., Surgeon Edinburgh Royal Infirmary. Volume III, Operative Surgery, with 220 illustrations. Edinburgh, Glasgow and London, Henry Frowde and Hodder and Stoughton, 1912.

The present volume of this work is devoted to operations on the Blood Vessels, on the Nerves, Bones, the Brain and Spinal Cord, Air Passages, Breast, Abdominal Organs and the Generative Organs. The authors have devoted a special chapter to the technique of abdominal surgery in which they deal with the various "Incisions in the Abdomen," the "Closure of Abdominal Wounds," and the "Types of Suture" suitable for various conditions. The volume is profusely illustrated and the reader is able to readily follow the descriptions in the text by means of diagrams and illustrations that accompany it. A commendable feature of the book is the small size of the volume which makes it very convenient for reading.

**Infant Feeding.**—By Clifford G. Grulee, A. M., M. D., Assistant Professor of Pediatrics at Rush Medical College, Attending Pediatrician to Cook County Hospital. Octavo of 295 pages, illustrated. Philadelphia and London. W. B. Saunders Company, 1912. Cloth, \$3.00 net.

In this volume the writer has endeavored to bring together the latest knowledge of the scientific processes which underlie infant feeding and to set forth the practical application of these principles in a clear and concise manner.

Many of the views and methods set forth by the author are at variance with the opinions held by leading American writers on the subject and conform more closely to those of the Continental practitioners. In fact, the author has referred freely to leading German authorities throughout his work and especially to the writings of Finklstien.

In addition to discussing the various phases of infant feeding the author has devoted considerable space to those diseases that result from improper nutrition. It is a work which contains much useful information and is well worthy of the serious consideration of any physician interested in this subject.

The Denver Chemical Mfg. Co., manufacturers of Antiphlogistine, are to be congratulated on securing the services of Mr. Harold B. Scott as manager of the company, to succeed J. C. Bradley, who is retiring from that position. Mr. Scott is a bright, energetic young man, a graduate of Yale University with the degree of A. B. Upon his graduation from college he entered the commercial world where he has enjoyed a wide, varied and successful experience in developing one of the great industries of our country. He is peculiarly well fitted for the management of a proprietary house, and his connection with Antiphlogistine will doubtless lead The Denver Chemical Mfg. Co. to spell success with larger letters than ever before.

**Honorary Degree Conferred on Dr. Amos J. Givens.**—Wesleyan University this week selected three men upon whom to confer the highest honorary degree. One was Gov. Simeon E. Baldwin, scholar, jurist and statesman. Another was President Murlin of Boston University. The third was Dr. Amos J. Givens of Stamford. It is understood that the University regarded Dr. Givens as worthy of this high honor first of all because of his achievements for the benefit of humanity. He has written numerous treatises upon diseases of the nervous system, and the effects of over-indulgence in alcohol and narcotics and works pertaining to various forms of insanity. The University, however, is said to have been still more impressed by the successful work he has carried on for twenty-one years in his sanitarium in Stamford. That Dr. Givens has been able through this institution to restore thousands of people to health, that hundreds of the brightest and best men and women in the country have been cured of the most baffling of all diseases, those which affect the nervous system, and have been sent back to useful labors with renewed health, must be regarded as a service to mankind. Every good physician is doing, every day, work whose value can be rightly estimated only when one considers the value of health and life. Dr. Givens has been doing that sort of work upon a larger scale, because he has made for himself large opportunities, and because he has devoted his life to one of the most difficult branches of his profession.—(Reprint from editorial in "Stamford Advocate," Stamford, Conn., June 22, 1912).

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#### PENNSYLVANIA STATE NOTES FOR OCTOBER, 1912.

**The Lehigh Valley Homœopathic Medical Society**, held its quarterly meeting at the Eagle Hotel, at Bethlehem, September 5, 1912. The president, Dr. Walter A. Seibert, of Easton, in the chair. Dr. Ralph Bernstein, of Philadelphia, was the guest of the society, and gave a Stereoscopic Skin Clinic, being a lantern demonstration of "The More Common Skin Diseases—Their Recognition and Treatment." The meeting was well attended, and a hearty discussion entered into.

C. S. Swartz, M. D., Secy.

**The Woman's Homœopathic Medical Society**, of Pittsburgh, Pa., held its regular monthly meeting at the home of Dr. Clara H. Williams, Rosedale Place, Verona Road, on Thursday, September 12, 1912, at 5 P. M. The Annual Corn Roast was a special feature of the occasion, and was enjoyed by all present.

Mary E. Coffin, M. D., Secy.

**The Homœopathic Medical Society**, of the 23rd Ward, of Philadelphia, held its regular monthly meeting at the Hotel Phoenix, Willow Grove, Wednesday, August 8, 1912. A very interesting paper on "The Infection in Contagious Diseases," was read by Dr. Frank Watson. There was a full attendance of members, and the meeting was enjoyed by all present.

J. D. Boileau, M. D., Secy.

**The Oxford Medical Club**, held its regular monthly meeting at Mayer's, 1620 North Broad street, on September 6, 1912, at 9 P. M. A very inter-

esting paper on "Midwifery" was read. The meeting proved a very enjoyable one, and was well attended.

C. W. Simmons, M. D., Secy.

**The North Penn Homœopathic Medical Society**, held its regular monthly meeting at the residence of Dr. S. C. Moyer, Lansdale, Pa., on August 22, 1912. The scientific program of the meeting consisted of the following: "The Homœopathic Idea," Dr. Wm. G. Moyer, Quakertown, Pa. Discussion, "Tuberculosis," Dr. D. M. Landis, Perkasio, Pa. The meeting was an interesting one, and was well attended.

H. O. Williams, M. D., Secy.

**The Goodno Medical Society**, held its regular monthly meeting at Columbia, Pa., August 8th. The members of the society were entertained at dinner by the members of the homœopathic profession of Lancaster County. The following scientific papers were then read: "A Plea for Gynecology," Dr. John Reith; "High Potency in Acute Cases," by Dr. H. C. Brown; "Mistakes," by Dr. S. S. Mann; "Acute Pulmonary Phthisis," by Dr. I. L. Moyer; "An Intestinal Case," by Dr. R. L. Perkins.

Brantly F. Parker, M. D., Secy.

**The Homœopathic Medical Society of the County of Philadelphia**, held its regular meeting at the Hahnemann Medical College on September 12th. The newly elected president, Dr. H. L. Northrop, delivered the Annual Presidential Address. Dr. O. S. Haines read an excellent paper on the "Therapeutic Action of Apis Mellifica."

**The Philadelphia Society for Clinical Research** held its regular monthly meeting at the Hotel Majestic, Philadelphia, on Wednesday evening, September 25th. Dr. Malachi W. Sloan read an excellent paper dealing with "Public Health and the Medical Profession." After the scientific program, the members of the society were entertained at dinner by Dr. Walter Cheesman.

**The Forty-ninth Annual Session of the Homœopathic Medical Society of the State of Pennsylvania** was held at Delaware Water Gap, September 17, 18, 19, 1912. The president, Dr. Gilbert J. Palen, of Philadelphia, called the meeting to order at 9.30 A. M., and after a prayer by the Rev. W. B. Jones, Dr. W. W. Speakman, of Philadelphia, delivered the address of welcome in his usual witty and pleasing manner. Dr. William A. Stewart, of Pittsburgh, in a short speech in response to the address of welcome, extended his thanks on behalf of the society to the members from the eastern part of the State, for the preparations they had made for the entertainment of the society. Dr. Palen then delivered the annual address of the president in which he called attention to the fact that the requirements for medical education have been increased and the standard of medical colleges has been very greatly raised. In our State the greatly dreaded Single Board of Medical Education has had its first inning, and much has developed, many things are in their infancy, which may bring future developments of an interesting nature.

Until this year the medical institutions were allowed to go their own ways, the result being that in many instances their teachings were insufficient, their graduates ill trained and poorly fitted to pass the rigid



examination of the various State boards. This year we find a tendency to get at the root of the evil; to cure the disease by removing the cause. In other words, the various institutions have been forced to undergo rigid examinations, their equipment, their methods of teaching have been carefully probed.

The work of the Board of Medical Education and Licensure has been a hard one, but one which has brought to light much of interest. It has been a work this year largely of accumulation of data but a work which should mark the beginning of great ultimate improvements if it is carried on as honestly and conscientiously as we believe it has been done this first year. The work of this Bureau will spell for some of our medical institutions either success or failure; it means for the future the "survival of the fittest," it means for the graduate of medicine, absolute assurance that if he can pass his college examinations he need have no fear but that he will receive his license to practice. I shall not dilate upon the work of this Board for this you will hear later on in our meeting, from Dr. Maddux. Suffice it to say, that we as homœopaths, have every reason to be proud of the excellent comparative showing of our institution and its graduates. I cannot refrain, however, in passing from this subject to mention the peculiar fatality by which we lost from this Board two of our excellent members, first, my very dear and greatly admired friend, Dr. Gustave A. Muller, and our good old staunch and loyal member, Dr. Seip.

As members of our society we owe it to the great State of Pennsylvania to make this State the center, the first in all matters medical. This State must and will ultimately set the standard for medical education. As homœopaths, we must, therefore, in addition, aim to make this State the greatest center of our school and we should as a society and as individuals help to bring this about.

The regular routine business of the Society was then taken up and the officers of the various committees made their reports. (A complete statement of the Reports of Officers will be published in an early issue of the "Hahnemannian"). A resolution was presented by Dr. D. P. Maddux, of Chester, and endorsed by Dr. R. W. McClelland, of Pittsburgh, and Dr. C. S. Middleton, of Philadelphia, to instruct the legislative committee to formulate an act that will tend to the registration and regulation of the practice of mid-wives in this State. This resolution was passed by the Society.

The following officers were elected: President, H. S. Nicholson, Pittsburgh; First Vice-President, M. M. Slaegle, Hanover; Second Vice-President, J. M. Heimbach, Kane; Recording Secretary, E. H. Pond, Pittsburgh; Treasurer, Ella D. Goff, Pittsburgh; Necrologist, W. F. Baker, Philadelphia; Censor, R. T. White, Pittsburgh; Associate Editor State Medical Journal, G. J. Palen, Philadelphia; Trustees, three years, M. W. Hillegas, Philadelphia; T. N. Johnson, Pittston, and N. J. Dietz, Hazleton.

#### Scientific Sessions.

The scientific work of the session was of an unusually high standard and we believe that all but three of the papers promised in the program were read.

The Bureau of Ophthalmology, Otology and Laryngology met on Tuesday morning and papers were presented by Dr. W. W. Speakman, Dr. Gilbert J. Palen, Dr. Charles H. Hubbard and Dr. Fred W. Smith.

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Under the Bureau of Obstetrics papers were presented by Dr. John E. James, Jr., Dr. Antoinette C. Russel, Dr. Leon Thurston, Dr. D. C. Kline, Dr. B. B. Fenimore.

Under the Bureau of Gynaecology papers were presented by Dr. Norman S. Betts, Dr. R. C. Casselberry, Dr. Nathaniel F. Lane, Dr. Roland T. White, Dr. C. I. Wendt, Dr. Mary Davis Ridgway, Dr. J. C. Calhoun.

Under the Bureau of Paedology papers were presented by Dr. Anna D. Varner, Dr. I. D. Metzgar, Dr. A. D. Dye, Dr. E. C. Blackburn, Dr. J. M. Heimback.

Under the Bureau of Pathology and Pathological Anatomy papers were presented by Dr. J. D. Elliott, Dr. Norman S. Betts, Dr. William M. Sylvis, Dr. R. S. Leopold, Dr. J. G. Wurtz, Dr. Frank O. Nagle and Dr. Frank J. Frosch.

Under the Bureau of Surgery papers were presented by Dr. H. M. Eberhard, Dr. D. Roman, Dr. W. N. Hammond, Dr. W. B. Van Lennep, Dr. H. L. Northrop, Dr. H. P. Leopold and Dr. G. A. Van Lennep.

Under the Bureau of Materia Medica and Provings papers were presented by Dr. Wm. A. Seibert, Dr. J. H. McClelland, Dr. Z. T. Miller, Dr. L. T. Ashcraft, Dr. Margaret H. Schantz, Dr. C. S. Raue, Dr. C. S. Kinney, Dr. J. W. Stitzell, Dr. J. V. F. Clay, Dr. H. S. Weaver, Dr. W. R. Williams, Dr. H. M. Eberhard, Dr. W. H. Yeager, Dr. Ralph Bernstein, Dr. August Korndoerfer.

Under the Bureau of Sanitary Science papers were presented by Dr. Walter S. Cornell, Dr. M. W. Sloan, Dr. R. E. Tomlin, Dr. E. G. Whinna.

Under the Bureau of Homœopathic Institutes and Clinical Medicine papers were read by Dr. G. H. Bickley, Dr. J. A. Fischer, Dr. George P. Stubbs, Dr. S. M. Rinehart, Dr. Percy H. Ealer, Dr. G. Morris Golden, Dr. C. Dudley Saul and Dr. Ralph Bernstein.

### **Social Features.**

From a social standpoint the meeting was probably the most successful one ever held in the history of the Society. The members being all housed under one roof had ample opportunity to renew old friendships and to form new ones, and a spirit of fraternalism and good fellowship prevailed from the beginning to the end.

On Tuesday evening a smoker was given by the members of the Philadelphia profession and one of the star features was a minstrel show, the parts being taken by members of the Society. It was the universal opinion of all present that this show was "the best ever" and the jokes and songs offered universal amusement.

During the latter part of the evening Dr. Wm. B. Van Lennep delivered an earnest and thoughtful address to the members of the Society on the work that is being done at the Hahnemann Medical College to educate men to enter the practice of homœopathic medicine. His appeal to the members of the profession to support the college in this work was received with universal enthusiasm and applause.

On Wednesday evening a banquet was tendered the visiting members and attended by a large gathering of doctors and their wives. Dr. Gilbert J. Palen acted as toastmaster, and a number of toasts were responded to by prominent physicians from all parts of the State.

Another notable feature of the meeting was the large attendance and the interest displayed by the wives of the physicians. Numerous automo-



bile trips, card parties and luncheons were held and every effort was made to give the visiting ladies a royal welcome.

On Wednesday evening the ladies met and organized an auxiliary association to help in the social affairs of the State meetings and to aid in promoting the interests of the homœopathic institutions of the State of Pennsylvania. The following officers were chosen for the ensuing year: President, Mrs. Alvah W. Stewart, Pittsburgh; First Vice-President, Mrs. W. A. Seibert, Easton; Third Vice-President, Mrs. Harold Cheney, Williamsport; Corresponding Secretary, Mrs. Harry F. Nicholson, Pittsburgh; Recording Secretary, Mrs. John E. James, Jr., Philadelphia; Treasurer, Mrs. Harry S. Weaver, Philadelphia; Directors, Mrs. Francis W. Boyer, Pottsville; Mrs. John A. Fisher, Philadelphia; Mrs. R. S. Castlebury, Chester; Mrs. Burlinghoff, Scranton; Mrs. S. M. Rinehart, Pittsburgh.

**The International Homœopathic Directory.** The publishers of the International Homœopathic Directory are collecting information for the 1913-1914 revision of the Directory. Dr. E. Petrie Hoyle, of London, England, has given a great deal of time and gratuitous work for the purpose of gathering together an accurate and comprehensive Directory of the homœopathic physicians of the world, together with such information relating to homœopathic hospitals, medical societies, etc., as would be of interest and value to the profession.

It is important that every homœopathic practitioner should forward at once to Dr. Hoyle his name and address and date of graduation. Any one who prepays four shillings is entitled to a brief card naming their specialty, appointments, etc. Details and remittance should be sent at once to the editor, Dr. E. Petrie Hoyle, 84 Holland Park W., London, England.

**Hahnemann Medical College.** The opening exercises of the Hahnemann Medical College of Philadelphia were held in the College Building on Monday evening, September 23rd. After a prayer by the Rev. Floyd W. Tomkins, Dr. D. Bushrod James delivered an address of welcome to the students and their friends on behalf of the faculty.

The Dean of the College, Dr. W. B. Van Lennep, then addressed the students in his usually concise and forcible manner and gave a brief outline of the aims of the college and of the work they would be expected to do during the coming year. He placed large emphasis upon the word "WORK."

After the formal addresses a reception and collation was tendered the students and their friends by the faculty.

The work of the college started this year under very auspicious conditions. Several new laboratories have been completed during the summer vacation, and all facilities for clinical and laboratory work have been brought to a strictly up-to-date condition. The Freshman Class shows a very decided increase in number over the Freshman Class of last year and the preliminary training of the men composing it is considerably higher than in former years. A number of additions have also been made to the more advanced classes and the prospects for a very successful year at Hahnemann were never better.

**Physician Wanted.**—There is an opening for a male physician on the staff of the Westborough State Hospital. Salary dependent upon experience in similar lines of work. Apply to H. O. Spalding, M. D., Superintendent, Westborough State Hospital, Westborough, Mass.

**Chauffeur's Complete Outfit Sacrificed.**—Consisting of elegant mink fur lined coat, Persian lamb collar \$35, pair of elegant bear robes \$15 each, raccoon cap \$5, pair of fur gloves \$4, pair of goggles 50c., one pair leather leggings \$3.50. Will sell separately or the lot, all new, never worn. Original price \$225. G. CHASE, 118 East 28th St., New York.

**Personals.**—Dr. W. Alvah Stewart, of Pittsburgh, Pa., was appointed on the Pennsylvania State Board for Medical Education and Licensure, in place of Dr. C. P. Seip, of Pittsburgh, Pa., deceased. Dr. D. P. Maddux, of Chester, Pa., was, as well, appointed to the board by the Governor.

Dr. J. M. Kenworthy announces the removal of his office to 1825 Chestnut street, Philadelphia.

Dr. Muhly announces the removal of his office to 1508 South Broad street, Philadelphia.

**The West Jersey Homœopathic Medical Society**, held its summer meeting at the Manor House, Collingswood, on Wednesday, September 11, 1912. The following program was prepared: H. B. Dean, M. D., "Notes on *Materia Medica*;" W. G. Schemeley, M. D., "Chronic Middle Ear Suppuration;" E. M. Howard, M. D., "Report of a Case;" W. McGeorge, M. D., "Reminiscences." After the scientific portion of the program the members were entertained at dinner by the president, Dr. E. S. Sheldon.

**To the Readers of the Hahnemannian Monthly:**—About six years ago the writer began to use vaccines in the treatment of typhoid fever. Since that time he has thus treated more than one hundred cases and has obtained numerous articles upon the same subject written by physicians in various parts of the world. It seems possible, however, that some may have escaped notice. He also realizes that many of the profession may have treated some cases without reporting them. A paper upon the subject is now in the course of preparation. In this it is earnestly desired to incorporate reports from a large number of cases, good, bad, and otherwise. He accordingly makes the following request to the readers of this journal:

Will any one who has used vaccines in the treatment of typhoid fever, whether but one case or more, kindly communicate to him that fact accompanied by name and address of the reporter. If the results have already been reported, a note of the journal in which they appeared will be sufficient. If they have not been reported, a short blank form will be sent to the physician to be filled out. Due credit will be given in the article to each person making a report. If any physician happens to know of other confreres who have any such cases, it will be appreciated if he sends their names, as they may not happen to read this note. It is hoped that by this means a sufficient number of cases may be collected to somewhat definitely settle the now mooted question whether vaccines are or are not of benefit in typhoid therapy.

Reports of cases will be accepted at any time in the future but preferably by November or December of the present year.

Kindly communicate with Dr. W. H. Watters, Director of the Department of Pathology and Bacteriology, Evans Institute for Clinical Research, Boston, Mass.

# THE HAHNEMANNIAN MONTHLY NEWS AND ADVERTISER

A Medical Newspaper

NOVEMBER 1912,

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**The Practice of Medicine. A Manual for Students and Practitioners.**—By Hughes Dayton, M.D., formerly of the Cornell University Medical School, New York. New (2d) edition, thoroughly revised. 12mo, 326 pages. Cloth, \$1.00 net. The Medical Epitome Series. Lea & Febiger, Publishers, Philadelphia and New York, 1912.

That this little work has received the approbation of students and physicians is shown by the demand which has brought it to a new edition. In order to present adequate information within brief compass, such subjects as diseases of the pharynx, larynx and tonsils, have been excluded (they are covered fully in the companion volume on the nose and throat) and the space thus gained has been devoted to the more important subjects in medicine, such as typhoid fever, tuberculosis and pneumonia. For the sake of simplicity the classification of Osler has been followed quite closely. In the present revision the same principles have been followed as in the former edition. The work has been thoroughly done throughout.

**A Text-Book of Obstetrics, Including Related Gynecologic Operations.**—The new (7th) Edition. A Text-Book of Obstetrics: Including Related Gynecologic Operations. By Barton Cooke Hirst, M.D., Professor of Obstetrics in the University of Pennsylvania. Seventh Revised Edition. Octavo of 1,013 pages, with 895 illustrations, 53 of them in color. Philadelphia and London: W. B. Saunders Company, 1912. Cloth, \$5.00 net; Half Morocco, \$6.50 net.

The seventh edition of this well-known work has been considerably



enlarged and modified in order that the most recent information on the subject might be incorporated in its pages. It includes in its scope not only those subjects usually considered under the subject of obstetrics, but also a description and consideration of the various operations for complications and the pathological consequences of the child-bearing process.

Dr. Hirst has had a wide experience as a consulting and attendant gynecologist and obstetrician in eight of the principal hospitals of Philadelphia and is thoroughly trained to present this important subject in such a manner as to guide undergraduate students and medical practitioners. The work can be recommended as being both complete and reliable and the present edition even surpasses in its scope and usefulness those that have preceded it.

**The Practice of Gynecology.**—Fifth Edition, thoroughly revised. A Text-Book on the Practice of Gynecology. For Practitioners and Students. By W. Easterly Ashton, M.D., LL.D., Professor of Gynecology in the Medico-Chirurgical College of Philadelphia. Octavo of 1,100 pages, with 1,050 original line drawings. Philadelphia and London: W. B. Saunders Company, 1912. Cloth, \$6.50 net; Half Morocco, \$8.00 net.

The first edition of this work was published in 1905 and such has been the popularity of it with the profession that five large editions and five reprints have been issued since that time. The success of the work is undoubtedly largely due to the practical manner in which the author presents his subject. Many minute details which are very important to the inexperienced practitioner and student, but which writers of works of this kind consider too trivial to present, are included, and physicians who desire to obtain information in regard to any of the procedures, diagnostic or operative, in the realm of gynecology will find them fully and completely described in this work.

In the present edition a number of alterations have been made and important additions added, especially along the lines of X-ray and electrical treatment.

**Progressive Medicine—A Quarterly Digest of Advances, Discoveries and Improvements in the Medical and Surgical Sciences.**—Edited by Hobart Amory Hare, M.D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia, etc., etc., assisted by Leighton F. Appleman, M.D., Instructor in Therapeutics, Jefferson Medical College, Philadelphia, etc., etc. Vol. III. September, 1912. Diseases of the Thorax and its Viscera, including the Heart, Lungs and Bloodvessels—Dermatology and Syphilis—Obstetrics—Diseases of the Nervous System. Lea & Febiger, Philadelphia and New York, 1912.

This volume of progressive medicine deals with diseases of the heart, lungs and bloodvessels, dermatology, obstetrics and diseases of the nervous system. The review of the literature on tuberculosis for the past year by William Ewart, contains much that is of interest and value to the medical practitioner.

The section dealing with the diagnosis of diseases of the heart is also a very interesting and valuable one. The section on dermatology, by William S. Gottheil, contains many interesting and important sug-

gestions. Dr. William G. Spiller has carefully reviewed the literature of the diseases of the nervous system and the portion devoted to a consideration of the uses of salvarsan in diseases of the nervous system is a very valuable one. In fact, the entire volume is replete with practical and useful information for the general practitioner as well as the specialist in the various lines.

**An Introduction to the Study of Infection and Immunity. Including Serum Therapy, Vaccine Therapy, Chemotherapy and Serum Diagnosis.**—By Charles E. Simon, M.D., Professor of Clinical Pathology and Experimental Medicine, College of Physicians and Surgeons, Baltimore. Octavo, 301 pages, illustrated. Cloth, \$3.25 net. Lea & Febiger, Publishers, Philadelphia and New York, 1912.

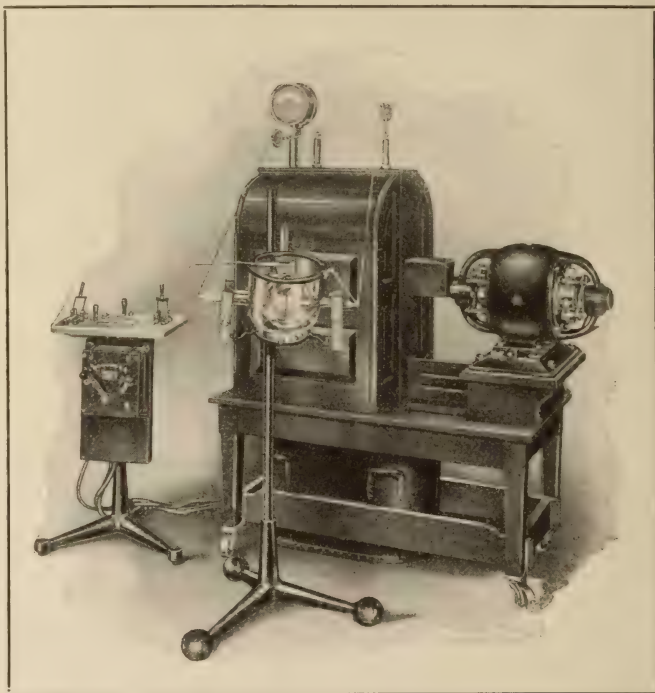
This work is an exposition of one of the most recent, most important and most promising developments which have thus far occurred in medical science, namely, the laboratory revelation of the processes by which the human organism protects itself from disease, or if the defence is overcome, by which the infections establish themselves. The results of the study of this subject are so far reaching and of such extreme practical value that every practitioner should familiarize himself not only with the essential basis upon which the new science of immunology has been established, but also with its application to diagnosis and treatment. The author has not attempted to cover the subject exhaustively, but has presented only representative methods, the intention being above all to emphasize the principles which are involved and to furnish an idea of the general character of immunological technique. New terms are introduced in a gradual manner, so that the physician may acquire them as he proceeds with his reading.

**A Manual of Auscultation and Percussion, embracing the Physical Diagnosis of Diseases of the Lungs and Heart, and of Thoracic Aneurysm, and of other parts.**—By Austin Flint, M.D., LL.D., late Professor of Medicine and of Clinical Medicine in the Bellevue Hospital Medical College, etc., New York. Revised by Haven Emerson, A.M., M.D., Associate in Physiology and in Medicine, College of Physicians and Surgeons, Columbia University, New York. 12mo, 361 pages, illustrated. Cloth, \$2.00 net. Lea & Febiger, Philadelphia and New York, 1912.

The revision and republication of this classic should be a source of gratification to all American physicians, for since its original appearance it has been recognized as a masterpiece of clarity and precision by one of the greatest of American teachers. To Professor Flint's advocacy more than to anything else is due the adoption in this country of the present methods of physical examination. The striking feature of his writings on physical diagnosis was the absence of theoretical speculation on the causation of signs. The importance of variations in pitch, which was his own discovery, was explained by him in the simplest manner. By a strict adherence to facts, he gave to his writings an enduring worth, so that it has been possible, with but few changes, to bring his Auscultation and Percussion up to the present state of the science. In this new edition the scope of the book has been widened by the inclusion of chapters on the examination of the abdominal viscera and of the nervous system.

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PHILADELPHIA, PA.



**Reports Requested.**—The American Surgical Association has appointed a committee consisting of Drs. William L. Estes, South Bethlehem, Pa.; Thomas W. Huntingdon, San Francisco, Cal.; John B. Walker, New York City; Edward Martin, Philadelphia; and John B. Roberts, Chairman, 313 S. 17th Street, Philadelphia, to report on the Operative and Non-Operative of Closed and Open Fractures of the Long Bones and the value of radiography in the study of these injuries. Surgeons, who have published papers relating to this subject within the last ten years, will confer a favor by sending two reprints to the chairman of the committee. If no reprints are available, the titles and places of their publication are desired.

John B. Roberts, Chairman,  
313 S. 17th Street, Philadelphia.

**A Whole Food Readily Assimilated.**—A product for artificial feeding that is a whole food completely assimilable without waste product to clog the alimentary tract or encourage fermentation processes should appeal with particular force to the medical profession.

Benger's Food will meet the most critical requirements of the Pediatrician or the general practitioner who requires a food containing the greatest possible nourishment in the most compact and convertible form.

In Benger's Food the presence of enzymes acting upon both the good and the fresh milk with which mixed, produces physiological action, converting the carbohydrates of the food into soluble sugars and changing the protein of the milk so that dense curds are not formed by the action of the gastric juices.

A doctor in Salt Lake City recently wrote us "My interest is vital, as your food has practically snatched my baby from a deathbed."

A request for samples addressed to the Benger's Food Company, 92 William Street, New York, will bring you a sufficient supply for clinical demonstration.

**Clinics at University of Michigan.**—The Clinical Faculty of the Homeopathic Medical College of the University of Michigan, Ann Arbor, will give a series of public clinics during the entire week of January 6, 1913, to which all members of the profession are invited. Doctors Stephen H. Knight and Rollin H. Stevens, both of Detroit, will co-operate with the Faculty of the College in their respective specialties. The clinics will be mostly operative, in the various departments of surgery. There will, however, be at least one medical and one nervous disease clinic and, perhaps, a few special lectures.

A special announcement is being prepared, giving hours and names. The announcement will be sent upon application to the Dean of the College.

**Extending to Other Countries.**—It is claimed that more "Storm Binders" are being sent out to every State in the Union, also to Canada, and even Mexico, than of any other make. This does not excite the least surprise on our part for from an extended experience with them we have come to regard them as well nigh perfect. We have yet to see a patient to whom we have applied one that has not expressed the utmost satisfaction, even gratitude.—(Editor of "Massachusetts Medical Journal," August, 1912.)

**Married.**—Mr. Frank Forester Jacques, of Chicago, announces the marriage of his daughter Abbie Lita, to Past Assistant Surgeon Wesley Hartman Rennie, United States Navy. The marriage occurred at Chicago, on November the eleventh. Dr. Rennie is a graduate of Hahnemann Medical College of Philadelphia and is now stationed upon the United States Ship Missouri.

Dr. Alexander Beck Arthur and Mrs. Marie Stewart Hammond announce their marriage on Thursday the fourteenth of November, one thousand nine hundred and twelve, in the city of Philadelphia.

**Personals.**—S. R. Kline, M.D., Ph.D., formerly of Fordham University Research Laboratory, has been appointed Director of the new Research Laboratory at Hahnemann Medical College, Chicago, Ill.

Dr. G. Harlan Wells announces the removal of his offices to 1807 Chestnut Street, Philadelphia. Diagnosis and Internal medicine. Office Hours: 8 A. M. to 12.30 P. M.; 5 P. M. to 8 P. M. Sunday by appointment.

Dr. H. Ward Fisher announces the opening of offices at Cor. E. Northampton Street and Park Avenue, Wilkes Barre, Pa. Office Hours: 8 until 10 A. M.; 3 until 4 P. M.; 6 until 8 P. M. Sunday, 8 to 11 A. M., only.

Dr. William Boericke, 306 and 308 Galen Building, S. E. Cor. Sutter and Stockton Streets, San Francisco. General practice—Homoeopathic treatment. Residence: 1812 Washington Street; Telephone, Franklin 72. Office Hours: 1 to 3 P. M. and Monday evenings 7.30 to 8.30. Telephone, Douglas 4163.

Dr. William Rendell Williams announces the opening of offices at 1825 Chestnut Street, Philadelphia. Diagnosis and Internal Medicine.

Dr. Edward H. Pond, 902 Kennan Building, Pittsburgh, Pa., announces a change of office hours to 10 to 1. Other hours by appointment. Dermatology, Physical Therapeutics.

The Knights Templar held their Field Day exercises in Fairmount Park, on Saturday, September 28, 1912. The following physicians were on the Corps Hospitalier: F. L. Abbott, M.D.; E. G. Whinna, M.D.; L. E. Marter, M. D.; A. C. Heritage, M.D.; C. S. Palmer, M.D.; and J. H. Closson, M.D.

Dr. Charles D. Fox announces his return from Europe. He will continue his office at 2126 Pine Street.

The Class of Nineteen Hundred and Twelve of the J. Lewis Crozer Hospital Training School held its commencement exercises on Wednesday afternoon, October 30th, at 3.30 in the Reception Hall of J. Lewis Crozer Home for Incurables, Upland, Pa.

Samuel H. Pettler, M.D., has opened an office at 705 Third Avenue, New Brighton, Pa. Skin diseases a specialty. Bell phone, 1059-J, Beaver County. Office Hours: 9 to 11 A. M.; 1 to 3 P. M.; 7 to 9 P. M.

A. Worrall Palmer, M.D., 260 West 57th Street, New York. Dr. Palmer desires to announce the resumption of his usual office hours on Tuesday, September 17th. Also his removal on October 1st to "The Oregon," 162 West 54th Street, Cor of 7th Avenue. Diseases of the Nose, Throat and Ear exclusively. Office Hours: 11 to 12 A. M., and by appointment. Tuesdays at 9 P. M. Phones: Office, Columbus 827; Residence, Prospect 701.

**CHAUFFEUR'S COMPLETE OUTFIT SACRIFICED.**

Consisting of elegant mink fur lined coat, Persian lamb collar \$35, pair of elegant bear robes \$15 each, raccoon cap \$5, pair of fur gloves \$4, pair of goggles 50c., one pair leather leggings \$3.50. Will sell separately or the lot, all new, never worn. Original price \$225. G. CHASE, 118 East 28th St., New York.

**The After Care of Children's Ills.**—With the advent of school-days and the daily association of many children in the class room, the contagious diseases of childhood develop and multiply. The exanthemata, as well as diphtheria, whooping cough, etc., comprise a considerable proportion of the diseases that the family physician is called upon to treat during the late fall and winter months. The robust child, with but a mild infection, frequently recovers quickly and, perhaps, requires but little attention during the convalescent period, while the child whose general nutrition is "below par" usually emerges from the acute attack with a condition of Anemia and general vital depreciation. In the large majority of cases, it is undoubtedly wise to encourage and hasten convalescence by means of a palatable and efficient hematinic and general tonic. For this purpose Pepto-Mangan (Gude) is especially valuable. All children like it and take it readily; it does not irritate the digestive organs, but, to the contrary, increases the appetite and assists in the absorption and assimilation of the child's nourishment. As it is non-astringent, it does not, as other ferruginous remedies do, cause or increase constipation. As Pepto-Mangan is prompt and efficient as a blood builder and general reconstructive, it should be preferred among children whenever medication of a general tonic nature is indicated.

**PENNSYLVANIA STATE NOTES.**

**The Interstate Federation of Homoeopathic Medical Societies of New York and Pennsylvania**, held its ninth annual meeting at the Hotel Rathbun, Elmira, N. Y. There were about sixty-five physicians from various cities of the two States in attendance.

Among the Philadelphia doctors present were: Doctor Gilbert J. Palen, president of the Homoeopathic Society of the State of Pennsylvania, and Professor of Otology, at Hahnemann Medical College, and Doctor Ralph Bernstein, Clinical Instructor on Skin Diseases, Hahnemann Medical College.

The opening session was held at two o'clock in the afternoon when an interesting and instructive program was presented. At seven o'clock dinner was served to the society members in the private dining room. The evening session opened in the hotel parlors at seven-thirty o'clock.

The program of the afternoon and evening was carried out by Richard O. Gregory, M.D., Elmira, N. Y.; F. C. Robbins, M.D., Hornell, N. Y.; E. H. Hill, M.D., Pittston, Pa.; R. V. White, M.D., Scranton, Pa.; W. H. Proctor, M.D., Corning, N. Y.; John E. Wilson, M.D., New York; S. C. Winters, M.D., Binghamton, N. Y.; Gilbert J. Palen, Philadelphia; A. W. Bailey, M.D., Atlantic City, N. J.; John M. Lee, M.D., Rochester, N. Y.; Ralph Bernstein, M.D., Philadelphia; J. L. Peck, M.D., Scranton, Pa.; W. M. Hilton, M.D., Waverly, Pa.; H. B. Ware, M.D., Scranton, Pa.; Frank T. Bascom, M.D., Rochester, N. Y.



The Homoeopathic Medical Society of Chester, Delaware and Montgomery Counties, held its fifty-fourth annual meeting in the Board of Directors' room of the Farmers' and Mechanics' Trust Company Building, on October 8th, thirty-seven physicians being present.

The President, Doctor John W. Pratt, of Coatesville, occupied the chair. After routine business had been disposed of the annual election of officers for the year took place, resulting in choosing the following: President, Dr. J. W. Pratt, Coatesville, Pa.; vice-president, Dr. Morris Hughes, Kennett Square, Pa.; secretary and treasurer, Dr. Isaac Crowther, Chester, Pa.; censor, Dr. H. E. Williams, Coatesville, Pa. After the election, Dr. S. A. Mullin read a paper on "The Advantages of Homoeopathic Treatment in Pneumonia with Statistics of Results." Following this the doctors adjourned to the roof garden where a banquet was served. After enjoying the good things and viewing the beautiful October scenery they re-assembled in the board room, and Dr. Ida V. Reel, of Coatesville, read a paper on "Comparative Medicine." This paper caused much discussion. This completed the program, and after the announcement that the next bi-monthly meeting would be held in Philadelphia, in December, the session adjourned.

Among the members and visitors present were: Drs. Isaac Crowther, Richard Casselberry, J. R. T. Gray, Charles H. Hubbard, D. P. Mad-dux, C. W. Perkins, C. W. Perkins, Jr., Franklin Powell, George C. Webster, of Chester, Pa.; Morris Hughes and A. W. Gregg, of Kennett Square, Pa.; Ida V. Reel and J. W. Pratt, Coatesville, Pa.; Mary H. Smith and James Hallowell, of Parkesburg, Pa.; Howard Terry, of Phoenixville, Pa.; W. D. Kennedy, of Lansdowne, Pa.; C. S. Middleton, Ralph Bernstein and Warren C. Mercer, Philadelphia, Pa.; E. M. Howard, of Camden, N. J.; Earnest L. Clark and Trimble Pratt, of Media, Pa.; Levi P. Hoopes, S. A. Mullin, J. O. Dicks, S. L. Barber and Charles Palmer, of West Chester, Pa.

The Homoeopathic Medical Society of the County of Philadelphia, held its regular monthly meeting at Hahnemann College, on Thursday evening, October 10th, 1912, at 9 P. M. The scientific program consisted of the following: "Clinical Therapeutics," O. H. Paxson, M.D.; "Pathology of Glaucoma," F. O. Nagle, M.D.; "Belladonna in Diseases of the Eye," P. A. Tindall, M.D.; "Belladonna in Diseases of the Ear," J. V. Clay, M.D.; "Belladonna in Diseases of the Nose and Throat," H. S. Weaver, M.D.

There was a full attendance of members and the meeting proved to be a very interesting one.

Wm. M. Sylvis, M.D.,  
Secretary.

The Homoeopathic Medical Society, of Wilkes Barre, Pa., held its regular monthly meeting, on Saturday evening, September 28th, 1912, at the Homoeopathic Hospital. Dr. S. A. Bullard gave an address on "Medicine and Surgery," as he observed it in Europe. Dr. D. S. Kistler gave a report of the State Society's annual meeting at Delaware Water Gap. The following officers were elected: President, Dr. E. C. Dreher; vice-president, Dr. Seth Kistler, of Nanticoke; secretary and treasurer, Dr. O. K. Grier.

The following were present: Drs. Seth Kistler, Nanticoke; C. C. Thompson, Kingston; Theodore Johnson and E. H. Hill, Pittston; H. H.

# Fellows' Syrup of Hypophosphites

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## NOTICE—CAUTION

The success of Fellows' Syrup of Hypophosphites has tempted many to offer imitations of it for sale.

As these cheap and inefficient substitutes are frequently dispensed instead of the genuine preparation, Physicians are earnestly requested when prescribing the Syrup, to write "**Syr. Hypophos. FELLOWS**".

As a further precaution, it is advisable that the Syrup should be ordered in the original bottles; the distinguishing marks which the bottles (and the wrappers surrounding them) bear can then be examined, and the genuineness—or otherwise—of the contents thereby proved.

Hoffman, Ashley; J. A. Bullard, D. S. Kistler, R. Murdock, E. C. Dreher, F. A. Whitman, O. K. Grier, and A. Fisher, Wilkes Barre, Pa.

The Homoeopathic Medical Society of the 23d Ward of Philadelphia, held its regular monthly meeting at the "Colonnade," on Wednesday, October 16, 1912. A very interesting paper was read on "Fractures." Doctor H. P. Leopold added much interest to the meeting.

J. D. Boileau, M.D., Secy.

The Clinico Pathologic Society of Philadelphia, held its regular monthly meeting at Hahnemann College, Saturday evening, October 19, 1912, at eight-thirty o'clock. There were some very interesting reports of clinical cases. The scientific program consisted of the following:

"Some Urinary Fallacies," John G. Wurtz, M.D.; "A Case of Leukemia treated with X-Ray," Drs. Sappington and Frank; "Discussion of Surgical Treatment of Enlarged Spleen," Drs. Northrup and Roman.

B. K. Fletcher, M.D., Secy.

The Germantown Homoeopathic Medical Society, held its regular monthly meeting at the "Majestic," Broad and Girard Avenue, on Monday, October 21, 1912, at 9 P. M. A paper was presented by Doctor Francois L. Hughes, after which a hearty discussion took place. Much interest was shown at the meeting, there being a full attendance of members.

Landreth W. Thompson, M.D., Secy.

The North Penn Homoeopathic Medical Society, held its regular monthly meeting at the office of Doctor H. O. Williams, Lansdale, Pa., on Thursday, October 3, 1912. Doctor Ralph Bernstein delivered a Stereoscopic Skin Clinic, demonstrating the more common skin diseases (in colors) giving their differential diagnosis and treatment with special reference to Homoeopathic treatment. The meeting was well attended, and a hearty discussion entered into.

H. O. Williams, M.D., Secy.

The Homoeopathic Medical Society of Chester, Delaware and Montgomery Counties, held its fifty-fourth annual meeting in the Board of Directors' Room, in the Farmers' and Mechanics' Trust Company's Building, on Tuesday, October 8, 1912, at one o'clock, West Chester, Pa. The scientific program consisted of the following: "Homoeopathy vs. Allopathy," I. Virginia Reel, M.D., Coatesville and Philadelphia.

A paper was read by Doctor S. A. Mullin, and was well presented. The annual election of officers then took place, after which dinner was served on the roof garden. There was a full attendance of members, and a delightful time was had by all present.

Isaac Crowther, M.D., Secy.

The Philadelphia Society for Clinical Research, held its regular monthly meeting at the office of Doctor F. C. Emery, Second Street Pike, Fox Chase, Pa. A very interesting paper was read by Doctor Emery, after which the election of officers took place. The meeting was well attended and enjoyed by all present.

Walter J. Snyder, M.D., Secy.

The Board of Managers of the Women's Southern Homoeopathic Hospital, held its annual meeting on Donation Day, Thursday, November 14th. Addresses were made by Mrs. Rudolph Blankenburg and Hon. E. L. Tustin. Solos by Miss Janet N. Scott and Miss Helene Reinhardt. The meeting was well attended and was a great success.



**Resolutions of Respect.**—On the fourth day of August, 1912, within one year of man's allotted three score years and ten, the soul of our fellow member, John Black McClelland, entered that silent bourne from which no traveler returns.

He gave four years of his early life to the loyal defense of his country; he gave thirty-three years of his life to the successful practice of Homoeopathic medicine, and was one of its most ardent, consistent and conscientious practitioners and defenders; he gave every year of his life to upright, conscientious and clean living.

His was a strenuous and intense nature, an original and forceful intellect and a positive and dominant will.

In the death of John Black McClelland this society recognizes that it has lost one of its most earnest and valued members, that Homoeopathy has lost a true, able and ardent advocate and exponent; that the State has lost a conscientious and faithful physician, and that society at large has lost a clean and Christian citizen, and as this Society laid its flowery meed of sorrow and sympathy on his bier, it directs that his life and character be spread upon its records, and transmitted to the surviving members of that trinity of medical brothers, so long members of this Society.

H. B. Bryson, M.D.,  
F. C. Sawyers, M.D.,  
E. R. Gregg, M.D.,  
Committee.

Allegheny County Homoeopathic Medical Society,  
Pittsburgh, Pa.

**Wanted.**—Resident Physician wanted for the West Jersey Homoeopathic Hospital, Camden, N. J. Board, uniform and salary to right man. Apply at once to Dr. C. F. Hadley, 3320 Federal Street, Camden, N. J.

**Some Valuable Products for the Treatment of Diseases of Bacterial Origin.**—Since the advent of diphtheria antitoxin it is doubtful if any new remedial agent has elicited greater interest than is now being manifested in the bacterial derivatives known as Phylacogens. These products were originated by Dr. A. F. Schafer, of California, the method of preparation and technique of application being first presented to the San Joaquin Medical Society in Fresno. To the uninitiated it may be said that the term Phylacogen (pronounced phy-LAC-o-gen) means "phylaxin producer," being derived from two Greek words signifying "a guard" and "to produce." The Phylacogens are sterile aqueous solutions of metabolic substances generated by bacteria grown in artificial media. They are produced from a large variety of pathogenic bacteria, such as the several staphylococci, streptococcus pyogenes, bacillus pyocyaneus, diplococcus pneumoniae, bacillus typhosus, bacillus coli communis, streptococcus rheumaticus, streptococcus erysipielatis, etc.

Four Phylacogens are now offered to the medical profession: Mixed Infection Phylacogen (used in the treatment of bacterial diseases of unknown etiology), Rheumatism Phylacogen, Erysipelas Phylacogen, and Gonorrhoea Phylacogen. They have been thoroughly tested clinically and are said to be producing excellent results in the treatment of the various pathological conditions in which they are indicated. They are administered hypodermically—subcutaneously or intravenously—preferably by the former method, the latter being advised only in cases in

which a quick result is demanded. They are supplied in hermetically sealed glass vials of 10Cc. capacity.

The Phylacogens are prepared and marketed by Parke, Davis & Co., who have recently issued a 24-page pamphlet which describes them in detail—the process of manufacture, therapeutic indications, dosage, methods of administration—everything, in fact, that needs to be known by the man who desires to use phylacogens. Every physician in general practice, every practitioner who desires to keep abreast of the latest advances in bacterial therapy, should have a copy of this valuable booklet. Write to Parke, Davis & Co., at their general offices in Detroit, Mich., ask for the "Phylacogen pamphlet," and mention this journal.

**A State Meeting of the Hahnemann Medical Society** was held on Thursday evening, November 7th at Reading Homoeopathic Hospital.

Dr. C. B. Jennings, the president, presided at the meeting.

The members present were: Dr. C. B. Jennings, Dr. J. S. Rittenhouse, Dr. W. A. Haman, Dr. S. L. Dreibelbis, Dr. D. S. Kline, Dr. George Curry, Dr. P. Gerhardt, Dr. C. R. Haman, Dr. George I. Keen, Dr. A. S. McDowell.

Dr. George I. Keen, who was the essayist for the evening, read a paper on "Some Observations—Old and new—on Syphilis." The paper was discussed by Dr. W. A. Haman, Dr. D. C. Kline, Dr. Gerhardt, Dr. C. B. Jennings and Dr. George I. Keen.

The president appointed the following committees: Law—Dr. F. H. Lawrence, Dr. Leon Dreibelbis, Dr. C. R. Haman. Entertainment—Dr. A. S. McDowell, Dr. George Curry, Dr. D. C. Kline. Public Health—Dr. Mark, Dr. W. A. Haman, Dr. Gerhardt. Censors—Dr. Dreibelbis, Dr. W. A. Haman, Dr. P. H. Gerhardt. Dr. Leon Dreibelbis was appointed Essayist for December.

Dr. F. F. Massey was proposed for membership by Dr. Gerhardt. The matter was referred to the Board of Censors who reported favorably. Dr Massey was elected a member and the meeting was adjourned.

Dr. Frank H. Lawrence, Secy.

**The Homoeopathic Medical Society of Delaware State and Peninsula**, held its annual meeting at the Homoeopathic Hospital in Wilmington, Delaware, on Thursday, November 14, 1912. President W. F. Hoey, of Frederica, Delaware, presided.

The scientific program consisted of a symposium on acute rheumatic fever, papers being read by the following members of the Society: Dr. Frank F. Pierson, Wilmington, Del.; Dr. Florence M. Seward, Wilmington, Del.; and Dr. J. Harmer Rile, Wilmington, Del.

Considerable discussion followed the reading of the papers which was participated in by members and guests. The meeting was well attended, every homoeopathic physician in the State of Delaware with three exceptions being present.

**After the Baby Comes.**—The weakness and debility which usually follow childbirth are all too prone to linger. The burden of lactation is very apt to further prolong convalescence and increase the liability to all manner of complications. In such cases, vigorous tonic treatment is urgently required and the resulting reinforcement of vital processes promptly changes the situation.

# THE HAHNEMANNIAN MONTHLY NEWS AND ADVERTISER

A Medical Newspaper

DECEMBER 1912,

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**Pharmacology, Action and Uses of Drugs.** By Maurice Vejux Tyrode, M. D., Ex-Instructor of Pharmacology in the Medical School of Harvard University. Second edition, Philadelphia, P. Blakiston's Son & Co., 1012 Walnut street. Price, \$1.50.

The purpose of the author in writing this book was to furnish a small and concise text-book that would give the elementary facts relating to the action of drugs without entering into expansive discussions of disputed points. The arrangement of the book is such that groups of drugs having similar action are taken up and their physiological action briefly outlined. The therapeutic application of the group is then considered and the various preparations of the drugs with dosage, etc., is given. It is an ideal work for students entering upon the study of drug action.

**The Principles of Human Physiology.**—By Ernest Henry Starling, M. D., (London), F. R. C. P., F. R. S., Jodrell Professor of Physiology in University College, London. Octavo, 1423 pages, with 564 illustrations, some in color. Cloth, \$5.00 net. Lea & Febiger, Philadelphia and New York, 1912.

Physiology is generally recognized as the most difficult of description of any subject in medicine, and books thereon of a high order of merit are correspondingly scarce. A work from the pen of an authority of such eminence as Dr. Starling should, therefore, attract wide attention, and should at once take a leading place among the text-books in this important department. In this volume the author has covered his subject in a way quite different from that which characterizes most works



on Physiology. He lays special stress on the significance of the various data, and points out from them the principles which are guiding physiologists and physicians in their efforts to extend the bounds of the known and to increase their powers of control over the functions of living organisms. Throughout the work the author has sought to show that the only foundation for rational therapeutics is the proper understanding of the working of the healthy body, for ignorance of physiology tends to make a medical man as credulous as his patients, and almost as easily beguiled. The work, therefore, has a distinctly practical bearing, and points out the applications to clinical medicine of the principles discussed. Its careful study should be of great value to both student and practitioner in equipping him for his struggle against the factors of disease.

**The Practitioner's Encyclopedia of Medicine and Surgery In All Their Branches**, edited by J. Keogh Murphy, M.C., (Cantab.), F. R. C. S., Surgeon Miller General Hospital for South East London, Senior Assistant Surgeon to Paddington Green Children's Hospital. London, Henry Frowde, Hodder & Stoughton, Oxford University Press, Warwick Square, East and 35 West 32nd Street, N. Y.

The general public, more than ever before, inclines to the belief that the practitioner of medicine is or at least ought to be, fully informed upon every department of medicine from the relative merits of health resorts and the comparative virtues of patent foods to the significance of a new operation performed by some distinguished specialist and duly reported in the lay press. It is, therefore, indispensable that he should have some ready access to information along general medical lines that will be up-to-date and authentic.

The Practitioner's Encyclopedia of Medicine and Surgery, is designed to meet this need. Experts in the various departments of medical science have been engaged to contribute the latest and most definite information obtainable along their various lines.

The subject matter is divided into five parts as follows:

- Part I—General Medicine;
- Part II—Surgery;
- Part III—Obstetrics and Gynecology;
- Part IV—Special Regions;
- Part V—Special Forms of Treatment.

Under each of these headings we have discussed all the various conditions that the physician is likely to desire information upon and each subject is presented by some well-known authority in his particular line.

The work is gotten up in a very convenient style, in large type and light white paper and contains within its more than fourteen hundred pages a very comprehensive, accurate and up-to-date summary of modern medical knowledge.

**The Practitioner's Visiting List for 1913.** An invaluable pocket-sized book containing memoranda and data important for every physician, and ruled blanks for recording every detail of practice. The Weekly, Monthly and 30-Patient Perpetual contain 32 pages of data and 160 pages of classified blanks. The 60-Patient Perpetual consists of 256 pages of blanks alone. Each in one wallet-shaped book, bound in flexible leather, with flap and pocket, pencil with rubber, and calendar for two years. Price by mail, postpaid, to any address, \$1.25. Thumb-letter index, 25 cents extra. Descriptive circular showing

the several styles sent on request. Lea & Febiger, Publishers, Philadelphia and New York.

Being its twenty-ninth year of issue, *The Practitioners' Visiting List* embodies the results of long experience and study devoted to its development and perfection.

It is issued in four styles to meet the requirements of every practitioner: "Weekly," dated for 30 patients; "Monthly," undated for 120 patients per month; "Perpetual," undated, for 30 patients weekly per year, and "60 Patients," undated, for 60 patients weekly per year.

The text portion of *The Practitioners' Visiting List* for 1913 has been thoroughly revised and brought up to date. It contains, among other valuable information, a scheme of dentition; tables of weights and measures and comparative scales; instructions for examining the urine; diagnostic table of eruptive fevers; incompatibles, poisons and antidotes; directions for effecting artificial respiration; extensive table of doses; an alphabetical table of diseases and their remedies, and directions for ligation of arteries. The record portion contains ruled blanks of various kinds, adapted for noting all details of practice and professional business.

Printed on fine, tough paper suitable for either pen or pencil, and bound with the utmost strength in handsome grained leather, *The Practitioners' Visiting List* is sold at the lowest price compatible with perfection in every detail.

**The Physicians' Visiting List for 1913.**—Sixty-second year of its publication. P. Blakiston's Son & Company, 1012 Walnut Street, Philadelphia. Price, 1.25 net.

This Visiting List has been so long before the profession that a lengthy description of its character and contents is unnecessary. It contains blank leaves for noting the nature of visits, for the addresses of patients and nurses, obstetric engagements, records of births, deaths, cash account, etc. It also contains tables of incompatible drugs, antidotes for poisons, quarantine periods, infectious diseases, dose tables, etc. The book is neatly bound in black and is of a convenient shape and size for the physician to carry in his pocket.

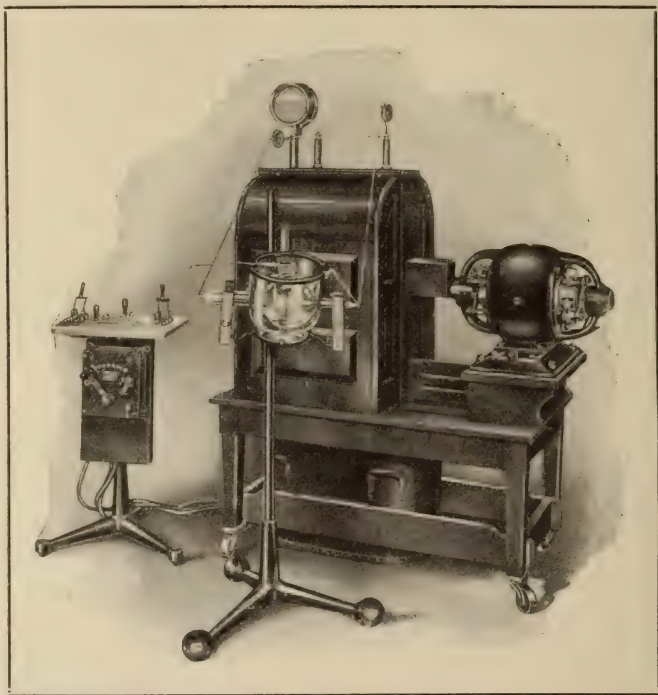
**Oxford Medical Publications—Pathology of the Eye.**—By P. H. Adams, M.A., M.B., D.O. Oxon., F. R. C. S., Surgeon to Oxford Eye Hospital, etc., London, Henry Frowde: Oxford University Press, Hodder & Stoughton: Warwick Square, E. C.

This little volume of two hundred pages is founded upon a series of lectures and demonstrations prepared for physicians attending the course in Pathology at the Oxford University.

After a general review of the pathology of the eye, the patient takes up in separate chapters the diseases of the Conjunctiva, of the Cornea, of the Iris, of the Ciliary Body, the Lens, the Retina, the Choroid, the Optic Nerve and Glaucoma. A chapter on general diseases affecting the eye is also included. The important facts in regard to the various subjects discussed are stated briefly and in a manner that can be readily comprehended by those who are not specialists in eye diseases. The book is well illustrated and can be highly commended to general practitioners and to students desiring to obtain authentic

## X-Ray Apparatus and Accessories

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Are you using every aid in your diagnosis work?

Ask us about our apparatus and our methods. We are the originators of reliable X-ray apparatus.

There are many imitations, but none its equal. We compete in quality but not in price.

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PHILADELPHIA, PA.



information in regard to the fundamental facts relating to the pathology of the eye.

**Brain and Spinal Cord.**—A Manual for the Study of Morphology and Fibre Tracts of the Central Nervous System.—By Dr. Med. Emil Viltiger, Privatdocent in Neurology and Neuropathology in the University of Basle. Translated by George A. Piersol, M.D., Sc.D. Prof. of Anatomy in the University of Pennsylvania, from the third German edition with 232 illustrations. Price, \$4.00. Philadelphia and London: J. B. Lippincott Company.

This work is intended as a guide for the laboratory exercise in the study of the Central Nervous System and is divided into three parts. Part I. Embraces Morphology of the Brain and Spinal Cord. Part II. The Fibre Tracts. Part III. Consists of Serial Sections of the Brain-Stem.

So complete and accurate are the illustrations in this work that a close study of them will, to a very large degree, supply the place of actual specimens. There are 232 illustrations, many of them occupying a full page. It is the most complete work of its kind published in the English language, and Dr. Pierson is to be complimented on his work on this valuable and unique edition of English Medical Literature. Price, \$4.00.

W. B. Saunders Company, medical publishers, are now established in their new building on West Washington Square—an ideal site right in the heart of Philadelphia's new publishing center.

The remarkable success of this house and the rapid growth of their business, with the increased facilities which this growth demanded, necessitated removal to larger quarters. They therefore erected a seven story building, housing all their departments under one roof.

Constructed of reinforced concrete, the building is absolutely fire-proof and equipped with every modern aid for the manufacture and distribution of medical books and for the comfort and convenience of their employees.

A cordial invitation is extended the profession to inspect the new plant.

**Report of Southern Homoeopathic Medical Association.**—Nothing succeeds like success, and this is once more demonstrated in the case of the Twenty-ninth Session of the Southern Association Meeting, which was held in Richmond, Va. It was one of the most enthusiastic and successful meetings ever held by the organization. New life was instilled, many new members were added and every one was impressed with the bright future of the association.

The opening exercises were held in the Jefferson Hotel Auditorium on the evening of the first day. Dr. Royal S. Copeland, of New York City, delivered the formal address, "What is Homoeopathy?" The attendance was large. The papers presented covered all the field of medicine and surgery.

Dr. Ralph Bernstein, of Philadelphia, gave a Stereoscopic Skin Clinic and Reflectoscopic Lantern Demonstration of the more common skin diseases of childhood, their recognition and treatment. The session was well attended and a hearty discussion entered into.

Dr. Bernard S. Arnulphy's paper of Paris France, "The Istonic Plasma of Professor Reni de Quinton in treatment of children," was read by Dr. Harry B. Baker, of Richmond. This opened up a new line of thought. The subject was well presented and caused much favorable comment and discussion.

Dr. E. Stillman Bailey, of Chicago, Ill., read a paper on "Radium as a remedy in Carcinoma." The most intense interest was manifested. The doctor has for some time been interested in this subject and gave some very excellent results. Dr. Bailey commanded the undivided attention of a large audience. The doctor is a patient research worker.

Dr. William R. King, of Washington, D. C., read an interesting paper on "Imbalances of Extraneous Eye Muscles." He recounted numerous cases where extraordinary conditions have resulted from strain on the muscles of the eye. So it went on for three days, a large number of papers being presented and fully discussed.

The social features were an automobile ride to Abattoir Valentine Meat Juice Co. After inspection of the Abattoir, members of the Association were driven to the Valentine Museum. After viewing the collections in the museum, luncheon was served. October 17th the members and guests were taken for an automobile ride through Richmond, its suburbs and parks. Thursday evening, the members and guests were entertained at a banquet by the newly elected president, Dr. Wellford B. Lorraine. Dr. George Bagby officiated as toastmaster. Dr. A. Leigh Monroe, of Miami, Fla., gave us some reminiscences, which were heartily enjoyed.

The meeting was one long to be remembered, and too much can not be said for the Local Committee on Arrangements, of which Dr. Lorraine was chairman. The entertainment provided for their guests was more than could be expected. If they doubt our appreciation, let them invite us for a return "engagement."

Lee Norman, Secy.

**The Homoeopathic Medical Society of New York**, held its forty-sixth semi-annual meeting in association with the regular October meeting of the Western New York Homoeopathic Medical Society at the Hotel Lafayette, Buffalo, N. Y., on October 8th and 9th, 1912. An address of welcome was delivered by Mr. John Sayles, secretary to the Mayor of Buffalo, and was responded to by John W. LeSeu, of Batavia, N. Y.

Following the business sessions the Bureaus of Laryngology and Rhinology, Neurology, Ophthalmology and Otology, and Pediatrics made their reports.

The greater part of the afternoon was devoted to the consideration of the *Materia Medica*. Dr. William Dieffenbach's paper dealt with the verification of the symptoms of radium bromide. As yet this drug is used in an experimental way, but its use has met with good success in the few cases where it has been administered in treating malignant growths and some skin conditions. In a paper on his experience with lachesis, snake venom, Dr. Joseph Rieger of Dunkirk told of its successful use, and Dr. C. Spencer Kinney, of Easton, Pa., reported getting favorable results from hypericum.

Dr. Clarence A. Potter, another member of the staff at the Gowanda asylum, endeavored to show by his paper the better success of the homoeopathic treatment as administered at Gowanda and at Middletown, the other State homoeopathic institution, as compared with the allopathic treatment in the other eleven institutions for the insane in this State. Dr. Potter said he took his statistics from the reports of the New York

State hospital commission. He said: "The records show that during the last nine years, from 1903 to 1911, the percentage of recoveries in the allopathic institutions has been 25 per cent, as against an average of 33 per cent. at Gowanda and Middletown. During that period of nine years, 51,289 patients were committed to the eleven allopathic hospitals, so that about 4,000 more cures would have been effected if the institutions were all homoeopathic. The cost of maintaining a patient for a year in the State hospitals is \$189.71 per capita. The saving of this amount on 4,000 patients would have been appreciated by the taxpayers."

Dr. Potter also said that the death rate at the homoeopathic institutions was lower than the rate in the others. He concluded his paper with a brief discussion of the value of drugs in treating insane patients, saying that the use of aconite and belladonna in treating cases was often good when dealing with excitable patients.

The bureau of clinical medicine and pathology conducted the closing work of the session. Dr. Stephen P. Jewett of Buffalo read a valuable paper on "The Abuse of Milk in Medical Practice," and Dr. Laidlow contributed a brilliant article on diagnostic problems.

On Wednesday, the Bureaus of Obstetrics, Physical Therapeutics, Gynecology and Surgery made their reports and a number of interesting and instructive papers were presented.

The social features of the meeting were of an especially interesting character. Dr. George A. Critchlow was in charge of the entertainment which included automobile rides, a luncheon at the Park Club, an informal dinner at the Hotel Lafayette, which was followed by several vaudeville acts and stereopticon views.

Gray's Glycerine Tonic Composition is peculiarly serviceable as a reconstructive and restorative for the nursing mother, not only because of its notable efficiency in promoting functional activity throughout the body, but especially because of its freedom from all contraindications. Thus it can be freely administered both during pregnancy and thereafter without a fear of its producing any but the most substantial benefits to the offspring as well as to the mother. Few remedies are more effective for increasing the lacteal flow than "Gray's," inasmuch as it exerts its influence through improving the whole bodily nutrition rather than by stimulating a single function at the expense of the rest of the body.

**A Seasonable Reminder.**—Urotropin in full doses (adults 15 grains, children 2-6 grains three times per day), given in the early stages of a "cold," assisted by a mild saline laxative, is the modern method of "breaking it up," far preferable to and safer than quinine, phenacetin, acetanilid, etc.

Based upon its proven excretion by the mucous membranes of the entire respiratory tract, systemic Urotropin medication is also recommended as a routine measure in acute rhinitis, tonsillitis, catarrh, bronchitis, influenza and grippe.

This, however, is only one new field of usefulness of this most diffusible of drugs, which to many practitioners is still known only as a urinary antiseptic. Physicians, who have not yet received the new 20-page booklet on Urotropin, recently published by Schering & Glatz, New York, can obtain a copy of the same by addressing the firm, mentioning this journal. It is the best and most convenient way to become posted on Urotropin therapy up-to-date.



**Woman's Southern Homœopathic Hospital Dedicated.**—In the presence of a large number of friends of the institution, the new building of the Woman's Southern Homœopathic Hospital, at Broad and Fitzwater streets, was dedicated recently. The new structure, modern in every detail, stands as a monument to the energy of Miss A. M. Miller, and Dr. Amelia L. Hess. It is the outgrowth of a small dispensary they established at Seventh and Lombard streets in 1894. Both Miss Miller and Dr. Hess took part in the dedicatory exercises, making addresses. Dr. Mary Branson, president of the board of managers, presided. Others who made addresses were Miss E. S. Lowry, president of the Century Club, and the Rev. Edward Yates Hill, pastor of the First Presbyterian Church.

The new building was erected at a cost of \$70,000. There are sixty-five rooms. The first floor will be devoted to maternity cases, the second for surgical and the third for medical. The basement will be used as a dispensary. The staff will consist of thirty physicians, of whom twelve will be women. Ten rooms in the hospital are being furnished by friends of the institution. Five stories high, the building is fireproof, and is divided into six wards for adults, two for children, twenty-six private rooms, four sun parlors and a tiled roof garden. Light, heat for cooking and power will be furnished by electricity. The building has a frontage of 130 feet on Broad street and extends 120 feet along Fitzwater street. It is expected that the building will be ready for occupancy about the middle of next month, when patients will be transferred from the present hospital building at 724 Spruce street. Officers of the hospital are Dr. Mary Branson, president; Dr. Amelia L. Hess, vice-president; Miss A. M. Miller, secretary, and Mrs. Emma Speakman Webster, treasurer.

#### PENNSYLVANIA STATE NOTES, 1912.

The Homœopathic Medical Society of the County of Philadelphia, held its regular monthly meeting Thursday evening, November 14th, 1912, at eight thirty o'clock. A very interesting feature of the meeting was the discussion of "The Social Evil." Several noted physicians and many prominent laymen took active part in the discussion. Many other important matters were taken up. The meeting was well attended and proved to be extremely interesting.

William C. Sylvis, M.D., Secy.

The Clinico Pathologic Society of Philadelphia, held its regular monthly meeting at Hahnemann College, Saturday evening, November 16, 1912, at 9 P. M. The scientific program of the evening consisted of the following:

"The Positive Value of Urinalysis" .....Dr. Wm. A. Pearson.

"An Interesting Case of Typhoid Fever".....Dr. Wm. H. Yeager.

"Transverse Myelitis, Clinical and Pathological Report of a Case,"

Dr. R. S. Leopold.

A hearty discussion took place and the meeting was enjoyed by all present.

Benj. K. Fletcher, M.D., Secy.

The Philadelphia Society for Clinical Research, held its regular monthly meeting, Monday evening, November 25, 1912, at 9 P. M., at the office of Doctor J. E. James, 118 S. 19th Street. Doctor Leopold read a very interesting paper on "Serum Treatment," which was well presented, and was enjoyed by all the members. There was a full attendance of members and the meeting was an interesting one.

A. Tindall, M.D., Secy.

# Fellows' Syrup of Hypophosphites

*Its distinctive characteristics are :*

Uniformity of Composition,

Freedom from Acid reaction,

Stability in vacuo,

The property of retaining strychnine  
in solution for an indefinite period,  
and

Pre-eminence in arresting disease.

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*Reject* < **Cheap and Inefficient Substitutes  
Preparations "Just as Good."**

The Homœopathic Medical Society of the 23rd Ward of Philadelphia, held its regular monthly meeting, Wednesday, November 20, 1912, at the Hotel Stenton. A paper on "Duodenal Ulcer" was read by Doctor W. Nelson Hammond, and proved to be a very interesting feature of the meeting.

John D. Boileau, M.D., Secy.

The Homœopathic Medical Society of Delaware State and Pennsylvania, held its regular annual meeting in the parlors of the Homœopathic Hospital, Wilmington, Del., November 14, 1912.

Three new members were elected and Dr. E. Q. Bullock was elected president; Dr. J. W. Mullin, vice-president; Dr. V. D. Washburn, secretary, and Dr. H. W. Howell, treasurer. On motion duly carried a special legislative committee was appointed to act in conjunction with a like committee from the old school society that a bill might be prepared and presented to our next legislature authorizing the removal of the State Pathological Laboratory from Newark, Delaware, to the city of Wilmington. Objection being made to the present location of the laboratory on the ground of comparative inaccessibility to the majority of the practicing physicians in the State.

After supper the scientific program was presented, being a symposium on Acute Rheumatic Fever. Dr. Frank F. Pierson presented its etiology and pathology, Dr. Florence M. Seward covered its symptomatology and diagnosis, and Dr. J. Harmer Rile discussed its treatment.

The Society's guests, Drs. Augustus Korndoerfer, Oliver S. Haines, C. Harlan Wells, and William W. Williams, all of Philadelphia, added to the practical value of the symposium by their timely and scholarly elaboration of points either barely touched upon or omitted by the essayists.

It is of interest to note that in the State of Delaware there are 38 known homœopaths, 33 of whom are members of his Society.

Victor D. Washburn, Secy.

The Germantown Homœopathic Medical Society, held its regular monthly meeting at the "Majestic," Broad and Girard Avenue, on Monday, the eighteenth of November, 1912, at nine o'clock in the evening. A paper on "Deviations of the Septum" was well presented by Doctor George W. MacKenzie, after which a hearty discussion took place. There was a full attendance of members and the meeting was very interesting.

Landreth W. Thompson, M.D., Secy.

The West Philadelphia General Homœopathic Hospital and Dispensary, held its regular monthly meeting at 1234 No. 54th Street, on Tuesday evening, November 19, 1912. There were a large number of members present, and many matters of importance were taken up.

S. W. Reeves, M.D., Secy.

The Homœopathic Medical Society of Delaware County, held its regular monthly meeting in the Y. M. C. A. Building, Chester, Pa., Thursday, November 14, 1912, at 3.30 P. M. Doctor G. Harlan Wells, of Philadelphia, read a paper on "A Consideration of the Treatment of Pulmonary Tuberculosis, with special reference to Tuberculin Therapy." Lunch was then served at which many members were present. The meeting was a very interesting one, and enjoyed by all present.

Geo. C. Webster, M.D., Secy.



The Homœopathic Medical Society of Chester, Delaware and Montgomery Counties, held its Holiday meeting, Tuesday, December 10, 1912, at 1 P. M., at the Colonnade Hotel, Philadelphia. The scientific program consisted of the following: "Modern Methods in the Diagnosis of Diseases of the Stomach," Dr. G. Harlan Wells, Philadelphia; "Progressive Co-ordination of Mind and Body from a Physical Standpoint, as shown by a series of muscular movements," Carl B. Stanford, Physica! Director, Y. M. C. A., Chester.

The program was a splendid one, and was thoroughly enjoyed by a large number of members who were present, all of whom enjoyed a luncheon which was served. Isaac Crowther, M.D., Secy.

The Luzerne County Homœopathic Medical Society, held its regular monthly meeting at the Homœopathic Hospital, Pittston, October, 1912. A very interesting paper on "Vertigo" was read by Docor C. C. Thompson. Doctor O. K. Grier delivered an interesting treatise on "Comparative Materia Medica" and Doctor T. M. Johnson gave a report of the Homœopathic Interstate meeting held at Elmira, N. Y. The meeting was well attended and proved to be very interesting.

**Personals.**—Mr. and Mrs. John W. Ridpath announce the marriage of their daughter, Anna Phillis, to Dr. George Franklin Baer, on Tuesday, the nineteenth of November, one thousand nine hundred and twelve, Jenkintown, Pennsylvania. At home after January first, 5936 Alder Street, Pittsburgh, Pennsylvania.

The Hahnemann Hospital Training School for Nurses held its Graduating Exercises at the Holy Trinity Parish House, at eight o'clock, Tuesday, November twenty-sixth, 1912.

Dr. H. Ward Fisher announces the opening of offices at Cor. E. Northampton Street and Park Avenue, Wilkes Barre, Pa.

The Goodno Homœopathic Medical Society, held its annual banquet at the Wheatland Hotel, Lancaster, Thursday evening, October 17th. Papers were presented by Drs. R. D. Diehl, H. C. Brown, J. E. DeHoff, R. L. Perkins, G. W. Brose, B. F. Parker, W. E. Bomberger, and S. S. Mann.

The following officers were elected for the coming year: President, Dr. R. L. Perkins, Harrisburg; vice-president, Dr. John A. Shower, York; secretary and treasurer, Dr. W. E. J. Bomberger, Harrisburg; censors, Dr. J. H. Yeagley, York; Dr. S. S. Mann, Columbia; Dr. J. Willis Hartmann, Harrisburg.

Following the business and scientific part of the meeting, a banquet was held at which Dr. J. E. DeHoff presided as toastmaster. Toasts were responded to by a number of the members and the meeting proved both an instructive one from a scientific standpoint and an enjoyable one from a social standpoint.

The Homœopathic Medical Society of New Castle County, Delaware, held its regular monthly meeting on Friday evening, November 22, 1912, in the Rooms of the Board of Education, of Wilmington.

Two new members were elected and in this connection it may be well to report that in the city of Wilmington there are 28 homœopaths, 22 of whom are members of the County Society.

Dr. C. M. Allmond read a short paper on *Materia Medica*. This was in accord with the policy adopted by this Society, that homœopathic *materia medica* be emphasized by the reading of at least one paper on this topic at every meeting.

Dr. Ralph Bernstein, of Hahnemann College, Philadelphia, then delivered a lecture, or as he termed it: "A Reflectroscopic Skin Clinic." It has been the pleasure of the writer to listen to many lectures and addresses but this was, without exception, one of the most delightful lectures he has ever heard. It was attractive to the eye and extremely practical to the busy practitioner of medicine.

Dr. W. W. Speakman, of Philadelphia, was also a guest. Dr. Speakman took occasion to present to the Homœopathic Hospital, an enlarged photograph of Dr. Charles M. Thomas, which was accepted by the local profession with many thanks.

It seemed to be the unanimous opinion that this was one of the most delightful and practical meetings that the Society has ever held.

Victor D. Washburn, Secy.

**Pituitrin in Difficult Parturition.**—Every physician who has any considerable obstetrical practice owes it to himself and to his patients to familiarize himself with the oxytocic function of Pituitrin. Here is an agent which, according to reports in the medical journals of the Old World (notably of Germany)—if obstetricians adopt it generally, as now seems likely—is destined to rob childbirth of much of its pain and terror. What shall we say of such an agent that fails but once in over a hundred cases in which it is used? And that is just what happened in Dresden, according to a report of Vogt, of the Royal Gynecological Clinic of that city. Vogt adds: "It was not necessary to have recourse to forceps in a single instance in which Pituitrin was employed."

For the benefit of physicians who are uninformed on the subject, it may be said that Pituitrin is an extract of the posterior or infundibular portion of the pituitary gland. While in use for a number of years—chiefly, perhaps, as a hemostatic and heart stimulant—it is only of late, comparatively speaking, that its value in uterine inertia has been fully understood. The product is prepared and marketed by Parke, Davis & Co., to whom inquiries should be addressed for further particulars of this remarkable agent. Not very long ago the company issued a pamphlet in which a number of interesting and surprising case reports were published. We understand that copies of this Pituitrin pamphlet are still available and may be obtained upon application to Parke, Davis & Co., at their general offices in Detroit, Michigan.

#### CHAUFFEUR'S COMPLETE OUTFIT SACRIFICED.

Consisting of elegant mink fur lined coat, Persian lamb collar \$35, pair of elegant bear robes \$15 each, raccoon cap \$5, pair of fur gloves \$4, pair of goggles 50c., one pair leather leggings \$3.50. Will sell separately or the lot, all new, never worn. Original price \$225. G. CHASE, 118 East 28th St., New York.

**Wanted.**—Resident Physician wanted for the West Jersey Homœopathic Hospital, Camden, N. J. Board, uniform and salary to right man. Apply at once to Dr. C. F. Hadley, 3320 Federal Street, Camden, N. J.





